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WOMEN'S HEALTH HISTORY

What was your age at the start of menstruation? _____

When was your last period? _____ How long did it last? _____

How many days between periods? _____ Is your cycle irregular? _____

Do you use pads or tampons? _____ How many on heaviest day? _____

Do you get menstrual cramps or other problems? _____

Premenstrual warning symptoms before your period: (Grade intensity - 1=mild, 2=moderate, 3=severe)

- ___ Breast Tenderness ___ Bloating ___ Skin ___ Mood Changes _____
- ___ Headache ___ Cramping ___ Diarrhea ___ Appetite Changes _____
- ___ Low Back Pain ___ Constipation ___ Other _____

Do the above premenstrual symptoms get better with your period flow? _____

Do you have any vaginal discharge or irritation? _____

Do you have recurring vaginal or bladder infections? _____

Have you ever had gynecological or breast surgery? _____

Do you have a problem or past history of herpes, venereal warts or venereal disease? _____

When was your last pap? _____ Do you have hot flashes? _____

Breast Problems: Discharge Tenderness Swelling

Did you breast-feed your babies? _____ How long? _____

Current Method of Birth Control

- Not applicable Partner has had vasectomy or is otherwise sterile
- None Tubal Ligation Hysterectomy Other _____
- IUD Diaphragm Condoms Foam
- Pill (Name: _____ # of years taken _____)

Previous Method of Birth Control

- Not applicable Partner has had vasectomy or is otherwise sterile
- None Tubal Ligation Hysterectomy Other _____
- IUD Diaphragm Condoms Foam
- Pill (Name: _____ # of years taken _____)

Any questions or problems concerning sex? No Yes. Any pain or discomfort with sexual intercourse? No Yes.

Times pregnant _____ Living Children _____ Miscarriages _____ Abortions _____ Premature Births _____

Please complete information below concerning your pregnancies

No	Born Month/Year	Weight @ Birth	Sex	Length of Pregnancy	Delivery Type	Complications - Describe if any
1						
2						
3						
4						
5						

