Reset

Rooted Health & Wellness LLC

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General Information

Name_____ Date of Birth_____

Womens Health History:

Obstetric History (Check box and provide number if applicable)

☐ Pregnancy _____ ☐ Miscarriage_____ ☐ Abortion_____ ☐ Living Children_____
☐ Vaginal delivery _____ ☐ Cesarean_____ ☐ Term Birth_____ ☐ Premature Birth_____

Birth weight of largest baby _____ Birth weight of smallest baby _____

Complications with pregnancy or birth (gestational diabetes, pre/eclampsia, infections, tears, excessive bleeding, postpartum depression, issues with breast feeding)

_____

_____

Menstrual History

Age of Menarche _____ Date of last menstrual period _____ Length of cycle _____
Time between cycles _____ ☐ Sexually Active ☐ Currently pregnant ☐ Trying to conceive

Form of contraception:

☐ None ☐ Birth control pill ☐ Patch ☐ Nuva Ring ☐ Depo Injection ☐ Condom ☐ IUD
☐ Diaphragm ☐ Withdrawal method ☐ Natural family planning method ☐ Partner Vasectomy
☐ Tubal Ligation ☐ Other:_____

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If hormonal birth control, how long have you used? _____

Are you currently in menopause? ☐ Yes ☐ No Age of menopause: _____ Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery: _____

_____

Any hormone replacement therapy in, during, or after menopause and duration: _____

Last PAP/gyne exam:_____Findings:_____Last Mammogram:_____

Findings_____ Any breast biopsies: ☐ Yes ☐ No Fibrocystic/dense breasts: ☐ Yes ☐ No Breast calcifications: ☐ Yes ☐ No

Gynecologic history	**Yes**	**No**
Endometriosis	☐	☐
Fibroids	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Ovarian Cysts	☐	☐
Infertility	☐	☐
Frequent yeast infections	☐	☐
Frequent UTIs	☐	☐
Frequent vaginosis	☐	☐
Sexually transmitted infection	☐	☐
Other:	☐	☐
Other:	☐	☐
Gynecologic/Hormonal Symptoms		
Premenstrual:		
Bloating	☐	☐
Breast tenderness	☐	☐
Carb Cravings	☐	☐
Chocolate Cravings	☐	☐
Constipation	☐	☐
Decreased sleep	☐	☐
Depression/Sadness	☐	☐
Fatigue	☐	☐
Increased sleep	☐	☐
Irritability/PMS	☐	☐
Menstrual:	☐	☐
Clots	☐	☐
Cramps/pain	☐	☐
Heavy periods	☐	☐
Irregular periods	☐	☐
Migraines	☐	☐
No periods	☐	☐
Scanty periods	☐	☐
Spotting in between	☐	☐
Vaginal dryness	☐	☐

Vaginal itching	☐	☐
Vaginal odor	☐	☐
Low libido (sex drive)	☐	☐
Painful intercourse	☐	☐
Uncontrolled urination	☐	☐
Mood swings	☐	☐
Hot flashes	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Joint aches	☐	☐
Hair loss	☐	☐
Hair thinning	☐	☐
Fragile skin	☐	☐
Frequent weight fluctuations	☐	☐
Muscle loss	☐	☐
Excess sweating	☐	☐
Absent or little sweating	☐	☐
Palpitations	☐	☐
Other:	☐	☐
Other:	☐	☐

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