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**NAME: _____DATE OF BIRTH: _____**

**GYNECOLOGIC/BREAST HISTORY *(Women, please complete the following)***

| | Yes No | Comment(s) |
|---|---|---|
| **Menses/Pregnancies/Births** | | |
| Could you be pregnant? | ☐ ☐ | |
| Date of last menstrual period: | ___/____/___ | |
| How many pregnancies have you had? | #_____ | |
| How many live births have you had? | # _____ | |
| **Pelvic Floor Issues** | | |
| Do you have problems with leaking when you cough or sneeze? | ☐ ☐ | |
| Do you feel dry? | ☐ ☐ | |
| Do you feel "loose" vaginally since childbirth or menopause? | ☐ ☐ | |
| **Hormone Replacement** | | |
| Have you ever taken Estrogen? | ☐ ☐ | |
| Number of years taking Estrogen? | # years | |
| **Mammogram** | | |
| Date of last mammogram: | ___/____/___ | |
| Was it normal? | ☐ ☐ | |
| **Breast Health – Have you ever had:** | | |
| Bloody nipple discharge? | ☐ ☐ | |
| Non-bloody nipple discharge? | ☐ ☐ | |
| Injury to breasts? | ☐ ☐ | |
| Breast infections? | ☐ ☐ | |
| Pain in breasts? | ☐ ☐ | |
| Shoulder Pain? | ☐ ☐ | |
| Back Pain? | ☐ ☐ | |
| Grooving in Shoulders from bra straps? | ☐ ☐ | **Bra Size:**_____ **Cup Size:**_____ |
| Rash under Breasts? | ☐ ☐ | |

**PATIENT SIGNATURE: _____ DATE: _____**