FEMM

Health Information Form

Download, electronically fill out, sign and send this form to your FEMM Teacher

CLIENT INFORMATION

Date:

Name (First) (Last):

Date of birth (mm/dd/yyyy): Age:

Street address:

City / Town: State/ Province: Zip/ Postal code:

Country:

Phone number (Home): (Cell): (Work):

Email:

Ethnicity: Language(s) spoken:

Occupation

Marital status: ___ Single ___ Married ___ Divorced ___ Other (specify):

Reason for learning FEMM:

How did you hear about our program?

Physician: Phone number:

OB/GYN physician: Phone number:

GYNECOLOGIC HISTORY

Menstrual history

Age when menstrual periods began: Date of last menstrual period:

How long is your typical cycle (period to period)? How long is your typical period (bleeding)?

Is bleeding heavy, moderate, or light?

Have you ever experienced excessive bleeding? If yes, describe:

How painful are your worst periods? Any bleeding between periods?

Do you take medications with your periods? If yes, specify type:

Have you ever used hormonal contraception? (includes most IUDs)

If yes, specify types, dates of use and if problems were encountered:

If yes, specify if used for medical reasons, and for what condition:

Premenstrual symptoms

Please check if any symptoms are present before onset of period.

____ Irritability	____ Depression	____ Food cravings
____ Bloating	____ Fatigue	____ Weight gain
____ Breast tenderness	____ Headache	____ Other
____ Mood swings	____ Insomnia	

Average duration of symptoms: Severity of symptoms (Scale of 1-10):

Do you have persistent low mood?

Do you have excessive anxiety?

Have you ever had an eating disorder? If yes, explain:

Do you have difficulty sleeping? Do you use sleeping aids? If yes, specify type:

Infections

Have you ever had a vaginal or urinary tract infection? If yes, specify type and frequency:

Have you ever had an STI (sexually transmitted infection)? If yes, please specify type and treatment:

Date of last STI screening:

PAP history

Date of last PAP smear:

Do you have a history of abnomal PAP smear? If yes, describe:

Pregnancy information

	Date of birth	How many weeks at birth?	Weight	Sex of baby	Delivery (vaginal, c-section)	Other comments (preterm delivery, still birth, neonatal death, ectopic pregnancy, complications, etc.)
1						
2						
3						
4						
5						
6						

How many total pregnancies have you had? How many living children do you have?

How many total vaginal deliveries have you had? How many total caesarian sections have you had?

How many total spontaneous miscarriages have you had?

How many total induced abortions have you had?

Describe any serious problems with pregnancies:

Are you currently breastfeeding?

Do you want children in the future?

Have you been trying to conceive and for how long?

Have you had fertility treatment? Specify types and dates:

Surgeries/hospitalizations

Reason: Date:

Reason: Date:

Allergies *(Include any medications)*

Current medications *(Include any vitamins, supplements or herbal medicines)*

SOCIAL HISTORY

Do you drink alcoholic beverages such as beer, wine, other? How often?

Do you smoke? Packs per day: # years smoking:

Do you drink beverages with caffeine? How often?

Do you use recreational drugs? Specify:

Exercise type: How often?

CONSENT TO USE HEALTH INFORMATION

By signing below, I give permission for my health information to be used anonymously for education and research purposes of the FEMM program.
I have the right to withdraw my consent at any time.

Signature: Date:

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