
**For Women Only**

COMPLETE THIS SECTION ONLY IF YOU ARE (OR THE PATIENT IS) A WOMAN OVER 16 YEARS OF AGE.

Are you pregnant?

No Yes

Are you nursing?

No Yes

Are you taking birth control?

No Yes

Do you experience painful periods?

No Yes

Do you have irregular cycles?

No Yes

Do you have breast implants?

No Yes

Do you perform a regular self breast examination?

No Yes

Do you take hormone replacement therapy (HRT)?

No Yes

Do you take oral contraceptives?

No Yes

Estimate the date of your most recent PAP/pelvic exam: _____

Date of last mammogram? _____

Date of Last Menstrual Period? _____

If applicable how many previous pregnancies? _____

How were the babies delivered? _____