Valayza™

PATIENT HISTORY FORM

TODAY'S DATE ______________________________ Your age _________ DATE OF BIRTH __________________

YOUR NAME (Last) ___________________________ (First) ______________________ (M.I.) ______________

If you need more room, feel free to write on the back of this paper

YOUR PAST MEDICAL HISTORY

Please list any major medical conditions, diseases or problems that you have now or have had in the past:

____

____

PAST SURGERY or HOSPITAL ADMISSIONS

Please list any major operations or procedures or admissions to a hospital that you have had in the past

____

____

CURRENT PRESCRIPTION MEDICATIONS

Please list any prescription medicine that you are currently taking, and what it is for (or write NONE):

____

____

VITAMINS, HERBS AND SUPPLEMENTS

Please list any non-prescription vitamins, herbs or supplements that you are currently taking (or write NONE):

____

____

ALLERGIES

Please list any allergies you have to medications or to other substances (or write NONE):

____

____

SOCIAL HISTORY

Please list your usage (OR WRITE NONE) of any of the following substances - Tobacco, Alcohol, Marijuana, other drug use:

____

____

Describe your exercise routine: ___________________________________ How often? _______________________

FAMILY MEDICAL HISTORY

Please list any major medical conditions or diseases in any close relatives:

____

____

MENSTRUAL HISTORY

Please indicate below if you no longer have any periods or if you still have menstrual periods:

☐I do not have periods because ____

☐I still have periods and the date of my last normal period was ______________________________

Describe if you are having any problem with your periods: ______________________________

BIRTH CONTROL METHOD ____________________ If none, please enter reason ____________________

LAST Pap Smear (MM/YY) ______________ By who? ______________________ Results? ____________

PREGNANCY HISTORY

How many times in your life have you been pregnant? __________. If this number is not zero, please provide your pregnancy history in more detail (vaginal birth, C/S births, miscarriages…)

____

____

____

VAGINAL SYMPTOMS

Please check the box or place an X in the box if you have any of the following symptoms:

SCORING	Minimal or Rarely	Mild or Occasionally	Moderate or Often	Severe or Frequently
Abnormal Vaginal bleeding [post-menopausal, post hysterectomy, bleeding between periods]				
Pain during intercourse				
Pain after intercourse				
Urinary Urgency				
Wake up 2 or more times a night to urinate				
Vagina is too loose				
Vagina is too tight				
Vagina is too long				
Vagina is too short				
Vaginal Bleeding during or after intercourse				
Vaginal Burning				
Vaginal Discharge				
Vaginal Dryness				
Vaginal Irritation				
Vaginal Itching				
Vaginal Pain or Tenderness				
Poor Vaginal Lubrication During Sex				
Vaginal Odor				

Pt Name: ______________________________________