MEDICAL HISTORY: *please fill out the following table.*

Name:		Card number:	
Date of Birth:		Telephone:	
Address:		Referring MD Name:	

Have you been diagnosed with any of the following conditions?	**YES**	**NO**
Depression	○	◉
History of other mental health condition (please name):	○	○
Rheumatoid arthritis	○	○
Systemic lupus erythematosus	○	○
History of other autoimmune condition (please name):	○	○

GYNECOLOGICAL HISTORY: *please circle and fill out answers to the following questions.*

Age at first period:

Have you ever been diagnosed with PCOS? ☐ YES ☐ NO

Have you experienced infertility? ☐ YES ☐ NO

- Have you ever undergone in vitro fertilization (IVF)? ☐ YES ☐ NO

Have you undergone menopause? ☐ YES ☐ NO

- Age of menopause:
- How long has it been since you underwent menopause? Please circle
  ☐ <12 months ☐ 12-36 months ☐ 36-72 months ☐ >72 months

Please circle the type of menopause you experienced. ☐ NATURAL ☐ SURGICAL

Have you ever experienced hot flashes or night sweats? ☐ YES ☐ NO

- What age did your symptoms begin?:
- How long did your symptoms last?:

Have you ever used hormone replacement therapy (HRT)? ☐ YES ☐ NO

Did you experience any of the following conditions in pregnancy?	**YES**	**NO**	**Number of pregnancies affected**
Gestational hypertension	○	○	
Gestational diabetes mellitus	○	○	
Placental abruption	○	○	
Preeclampsia or eclampsia	○	○	
Preterm delivery	○	○	
Small for gestational age infant	○	○	
Large for gestational age infant	○	○	
Pregnancy loss or stillbirth	○	○	

Date: