GENE UPSHAW MEMORIAL
TAHOE FOREST CANCER CENTER

Patient Name (First, MI, Last)	**DOB**

FEMALE GYNECOLOGIC HISTORY

Pregnancy History			Comments
Have you ever been pregnant?	Yes ☐	No ☐	
If yes:			
How many times have you been pregnant?			
How many times have you given birth?			
What was your age at first birth?			
Did you breast feed?	Yes ☐	No ☐	

Menstrual History			Comments
What was your age at your first menstrual period?	_____		
When was your last menstrual period?	_____		
Have you stopped menstruating?	Yes ☐	No ☐	
Have you ever taken birth control hormones?	Yes ☐	No ☐	
Have you ever taken hormone replacement therapy?	Yes ☐	No ☐	