Patient Name: _____ Date: _____ ID:_____

Office Use Only

# Inquiry of Women's Health Status

1. General Information

   Age of 1st Menses: ____, # of Pregnancies_____, # of Children _____, # of Miscarriages____, # of Abortions_____

2. Your current menstrual cycle is □regular □irregular If irregular, how? _____

3. In general, how many days for the whole cycle (from the 1st day of one period to the 1st day of next)? _____

4. Please describe your most recent period: starting date_____ ending date_____

   Please check symptoms (all that apply) associated with your most recent period and describe details:

   How many days of bleeding ____ □light □normal □heavy spotting □yes □no details:_____

   Blood color □bright red □brownish □dark red clotting: □no clots □small □big □many □few

   Pain □low back □lower abdomen □other_____ □before □during □ after details:_____

   Quality of pain: □cramping □dull □sharp □achy □other:_____

   Emotional changes: □yes □no □before □during □ after details: _____

   Breast tenderness: □yes □no □before □during □ after details: _____

   Headaches: □yes □no □before □during □ after details: _____

   Abdominal distension: □yes □no □before □during □ after details: _____

   Edema: □yes □no □before □during □ after details: _____

   Other symptoms: _____

5. Types of feminine hygiene products used: □ pads □ tampons □ organic □ non-organic

6. Have your menstrual conditions changed since the first one to the most recent one? □yes □no

   If yes, please describe how/when it changed:_____

   _____

7. Do you have any vaginal discharge? □yes □no If yes, frequency:_____

   Appearance: □clear □white □yellow □watery □thick Amount: □light □medium □heavy

   Fishy order: □none □mild □strong Associated with menses? □yes □no Other:_____

8. Please list all the reproductive disorders diagnosed in Western Medicine and when: _____

   _____

9. Have you taken birth control pills, or other hormonal regulating medications/therapies? □yes □no

   If yes, please specify type(s) and how long? _____From_____ To_____

10. Have you received any surgical procedure for reproductive or menstrual disorders? □yes □no

    If yes, please specify _____

11. Other symptoms or concerns: _____

12. Obstetrician/Gynecologist's name and contact information:_____

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Clinician Name: _____ Signature: _____ Date Signed _____