

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 \_\_\_\_\_