Date last menses began /

Is your menstrual cycle: Regular ___ Irregular ___

How old were you when you had your first menstruation?

How many days do you bleed in total?
Menstrual cycle length (i.e. 26-30 days) /

Describe your flow: Heavy ___ Light ___ Average ___ Consistency of blood: Watery ___ Thick ___ Average ___

Does your blood contain clots? Yes ___ No ___ ...and... At which point during the cycle? Start ___ Mid ___ End ___

Describe the color of your blood: (red, dark red, brown, purple, brownish red, bright red, pink, etc)

Do you experience menstrual pain? Yes ___ No ___ Before menses ___ During _____ (please specify which days)

What relieves the pain? Stabbing ___ Cramping ___ Dull ___ Heavy ___ On/off ___

Do you experience pre-menstrual symptoms (PMS)? Please check all that apply.

Breast tenderness ___ Cramps ___ Acne ___ Change in bowel ___ Bloating ___ Headaches ___ Nausea ___ Moodiness ___
Fatigue ___ Night sweats ___ Sleep disturbances ___

Please list any other pre-menstrual symptoms

Do you ovulate on your own? Yes ___ No ___ What Day? _____ Do you chart your cycle? (circle) BBT / Ovulation sticks / Saliva

Do you experience pain around ovulation? Yes ___ No ___ Do your breasts get tender around ovulation? Yes ___ No ___

Do you notice stretchy clear egg white slippery cervical mucus around ovulation? Yes ___ No ___

How many times have you been pregnant? _____ How many times have you given birth? _____
Ages of children _____ Sex of children _____ Given names _____
Have you had any miscarriages? Yes ___ No ___
If yes, how many, at how many weeks pregnant, and in what year(s)?

_____
_

How many times have you had a D&C preformed? _____
How many abortions have you had? _____ In what year(s)? _____
Were there any problems that occurred during these pregnancies? _____

Have you ever been diagnosed with:

STD?	Yes__ No__	Date of last pap smear: _____/_____/_____ (dd/mm/yyyy)
Pelvic inflammatory disease?	Yes__ No__	
Uterine fibroids?	Yes__ No__	Have you ever had an abnormal pap smear? Yes ___ No ___
Polyps?	Yes__ No__	Have you ever had a cervical biopsy or operation? Yes ___ No ___
Pelvic adhesions?	Yes__ No__	
Prolapsed uterus?	Yes__ No__	Do you get yeast infections regularly? Yes ___ No ___
Unique shape of uterus?	Yes__ No__	Do you get bladder infections regularly? Yes ___ No ___
Endometriosis?	Yes__ No__	If answered yes, list STDs: _____
PCOS (polycystic ovarian syndrome)?	Yes__ No__	

Do you experience vaginal discharge? Yes ___ No ___
If yes, what colour?
White ___ Yellow ___ Green ___ Pinkish ___ Red ___
If yes, what consistency?
Watery / thin ___ Thick ___ Sticky ___
If yes, does it have foul odor? Yes ___ No ___

Have you taken oral contraceptives? Yes ___ No ___
If yes, for how long? _____
When did you stop? _____
Have you ever had an IUD? Yes ___ No ___
Have you ever taken Depo-Provera? Yes ___ No ___