

Number of days between periods: _____ Number of days period lasts: _____
Color of menstrual blood: (circle one) Bright red Dark red Purplish red Other: _____
Do you get cramps with your period: Yes No If yes, are cramps Strong? Or Dull? (circle one)
Do you get clots with your period: Yes No If yes, are clots Large? Or Small? (circle one)

Pregnancies: _____ # Live Births: _____ # Miscarriages: _____
Abortions: _____ # Premature Births: _____

Please circle all that apply.

Vaginal discharge	Frequent yeast infections	Birth control pills	Breast lumps
Fibroids	Ovulatory/mid-cycle pain	Ovarian cysts	Vaginal sores
Irregular periods	No periods	Short periods	Long periods
Mid-cycle spotting	Heavy menstrual flow	Light menstrual flow	

Other: _____

PMS: If you get PMS, please circle symptoms below. Please add any symptoms not listed.

Breast tenderness	Bloating of lower abdomen	Cramping	Acne
Irritability	Weepiness	Mood swings	Back pain
Headaches	Migraines	Water retention	Weight gain

Other emotional changes: _____
Other symptoms: _____

Infertility: If you wish to be treated for infertility, or if you have a history of infertility, please provide information below.

How long have you been trying to get pregnant? _____
When were you given a Western diagnosis of infertility? _____
What is your Western diagnosis? _____
What infertility medications have you taken? _____

Menopause: Age of onset: _____

Please circle any symptoms you are currently experiencing:

Hot flashes	Night sweats	Poor sleep	Memory loss
Osteoporosis	Osteopenia	Decreased sex drive	

Other: _____

Are you or have you been on Hormone Replacement Therapy? Yes No

If yes, were you on daily progesterone or cyclical progesterone? _____

Please list any other menopause related issues you would like to address: _____

Please list any other issues not discussed above you would like to address:

Name: _____ Date: _____