Name:										
Menstrual History]									
What age did menstruation begin?		PATIENTS ONLY: Or operienced the sympton				pertain to you, or if				
Are your periods:	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6				
Somewhat regular										
Erratic										
Like clockwork										
Total Boxes Checked:	Total Date:	Total Date:	Total Date:	Total Date:	Total Date:	Date:				
What is the interval between your menstrual cycle in days?										
If your period is erratic, please complete the following statement: "My period comes sometime betwee" days and days after completion or my previous cycle."										
During a typical menstrual period, how many days of bleeding do you have?						0.00				
Is your bleeding:	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6				
Heavy						5				
Light Normal										
Total Boxes Checked:	Total	Total	Total	Total	Total	Total				
	Date:	Date:	Date:	Date:	Date:	Date:				
Which of the following describes the										
predominant color of your menstrual blood?	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6				
Light Red										
Purple										
Brown										
Dark Red										
Black										
Bright Red										
Total Boxes Checked:	Total	Total Date:	Total Date:	Total	Total	Date:				

Menstrual History Continued	FOR LONG TERM F	ATIENTS ONLY: On	the day of your re-ex	am only check the boxe I up your boxes and ent	es that NO LONGER	pertain to you, or it	
Is there clotting with your period?	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6	
Yes						T	
No Total Boxes Checked:	Total	Total	Total	Total	Total	Total	
Do you regularly experience PMS:	Date:	Date:	Date:	Date:	Date:	Date:	
Yes No							
Total Boxes Checked:	Total	Total	Total	Total	Total	Total	
	Date:	Date:	Date:	Date:	Date:	Date:	
Check which symptoms best describe your PMS:	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6	
Breast tenderness or swelling							
Irritability							
Abdominal Bloating	\square						
Diarr rea					<u>'</u>		
Cons. pation							
Pair ! Cramping	Ш .						
Headaches or Migraines							
Mood Swings							
Low Back Pain							
Dizziness							
Extreme Fatigue							
Acne							
Food Cravings							
Total Boxes Checked:	Total	Total	Total	Total	Total	Total	
	Date:	Date:	Date:	Date:	Date:	Date:	
During your menstrual flow, how many times would you soak a tampon or pad in a 4 hour time?							

Menstrual History Continued						
During ovulation, is your cervical mucus:	experienced the syn	nptoms for two weeks. Ad	day of your re-exam only o			or if you HAVE NOT
	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Clear Abundant and Stretchy If not, please describe: Total Boxes Checked	Total	Total	Total	Total	Total	Total
					<u></u>	
What is the most important thing that you think your acupuncturist should know about your menstrual cycle?	Date:	Date:	Date:	Date:	Date:	Date:
Have you had a veneral disease?	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Yes No						
If yes, please describe:						
Total Boxes Checked	Total	Total	Total	Total	Total	Total
	Date:	Date:	Date:	Date:	Date:	Date:
Do you have a history with any of the following:	Re-Exam	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Yes No Regularly occurring yeast infectons						
└ 'ves No An abnormal pap smear						
es No Any kind of uterine surgery	! !		1 1			
	— ·					
Yes No Endometriosis					<u> </u>	
Yes No Chronic vaginal discharge						
Yes No Chronic vaginal discharge No Uterine fibroids or polyps						
Yes No Chronic vaginal discharge Yes No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease						
Yes No Chronic vaginal discharge Yes No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease Yes No Polycystic ovarian syndrome						
Yes No Chronic vaginal discharge Yes No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease						
Yes No Chronic vaginal discharge No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease Yes No Polycystic ovarian syndrome No Spotting or bleeding between periods Total Boxes Checked	Total	Total	Total	Total	Total	Total
Yes No Chronic vaginal discharge Yes No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease Yes No Polycystic ovarian syndrome No Spotting or bleeding between periods Total Boxes Checked Have you used oral contraceptives?	Date:	Total Date:	Date:	Total Date:	Total	Total Date:
Yes No Chronic vaginal discharge Yes No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease Yes No Polycystic ovarian syndrome No Spotting or bleeding between periods Total Boxes Checked						
Yes No Chronic vaginal discharge Yes No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease Yes No Polycystic ovarian syndrome No Spotting or bleeding between periods Total Boxes Checked Have you used oral contraceptives?	Date:	Date:	Date:	Date:	Date:	Date:
Yes No Chronic vaginal discharge Yes No Uterine fibroids or polyps Yes No Pelvis Inflammatory Disease Yes No Polycystic ovarian syndrome Yes No Spotting or bleeding between periods Total Boxes Checked Have you used oral contraceptives? If yes, please list the dates of use and disuse below:	Date:	Date:	Date:	Date:	Date:	Date:

Date of your last pap smear or ob/gyn exam: _____

Fertility History
Have you ever been pregnant before? No Yes Total number of pregnancies: Number of vaginal deliveries: Number of Cesarian (C-Section) deilveries: Number of Abortions: Number of Miscarriages: Number of still births:
If you have ever had a miscarriage, please list the week of pregnancy when the miscarriage occurred and the reason (if known):
During ovulation do you experience the following: Yes No Pain or cramping Yes No Bleeding or spotting Yes No Copious or excessive discharge Yes No Breast pain or tenderness
During ovulation is your cervical mucous Dense/cloudy Unknown Clear/stretchy
How long have you been trying to get pregnant?
No Yes Do you have a committed partner with whom you are trying to conceive? If yes, how long have you been married/living together?
No Yes Has he had a male fertility work-up? If yes, what were the results?
No Yes If no, do you intend to get one?

Fertility History	Continued
Yes No	Have you ever undergone fertility treatments or used Assisted Repro.Technology? If yes, please describe methods that you have used and the dates of each procedure:
Yes No	Have you ever taken medication to help you ovulate? If yes, when? And how long?
No Yes Yes No	Have your fallopian tubes been evaluated medically? If yes, were the results "obstructed" or clear/patent
No Yes	Have you had any hormonal lab tests done? If yes, when and what were 'e results?
Yes No	Have you been given any biomedical diagnosis that might explain why you are having trouble getting pregnant? If yes, what was it?
□ No □ Yes	Have you ever charted your Basal Body Temperature (BBT)?
110 103	If yes, please bring your charts to your next appointment.
Disregarding anyth	ing that anyone has told you previously, why do YOU think that you are having difficulty getting pregnant?
	e (10 being very commited), rate your commitment level to do whatever it takes to get pregnant? (including nd lifestyle changes / quitting smoking and drinking alcohol / taking herbs regularly).
My level of co	ommitment is: out of 10.

						
Health History		PATIENTS ONLY: C experienced the symptom				pertain to you, or
Kidney	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Yes No Do you have vaginal dryness?				T T		
Yes No Is your midcycle cervical mucus scanty or missing?						
Yes No Does your menstrual blood tend to be dull in color?						
Do you feel cold cramps during your period that						
Yes No respnds to heat?						
Total Boxes Checked	Total	Total	Total	Total	Total	Total
	Date:	Date:	Date:	Date:	Date:	Date:
Spleen	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Is your menstruaton thin, watery, profuse or pink in						
Yes No color?						
Are you more tired around ovulation or						
Yes No menstruaton?						
Have you ever been diagnos: 1 with uterine		1		1 1	i	
Yes No prolapse?						
Are your menstrual cram; 5 ompanied by a			· ·			
Yes No bearing-down sensation in your uterus?	 					LJ
Total Boxes Checked	Total	Total	Total	Total	Total	Total
	Date:	Date:	Date:	Date:	Date:	Date:
Blood	Re-Exam 1	Re-Exam 2	Re-Exam 3	Re-Exam 4	Re-Exam 5	Re-Exam 6
Yes No Are your menses scanty and/or late?						
Is your menstrual flow ever brown or black in						
Yes No color?						
Yes No Do you have painful, unmovable breast lumps?						
Can you feel any abnormal lumps in your lower						
Yes No abdomen?						
Do you have piercing or stabbling menstrual						
Yes No cramps?			L			
Total Boxes Checked	Total	Total	Total	Total	Total	Total
	Date:	Date:	Date:	Date:	Date:	Date:

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r , .	- 15 /							Re-Exam	n 3 Re-Exam 4		4	Re-Exam 5		Re-Exam	1 6
					<u> </u>	T	Ī	T	T			T			
Yes		No	Do you feel bloated or irritable around ovulation?]								
Yes		No	Does it feel as if your ovulation lasts longer than it should?												
Yes		No	Do you experience nipple pain or discharge from your nipples?												
Yes		No	Have you been diagnosed with elevated prolactin levels?												
Yes		No	Are your menses painful?]]				
Yes		No	Do you feel your menstrual cramps in the external genital area?												
Yes		No	Is the menstrual blood thick and dark, or purplish in color?												
	Tota	Воз	xes Checked		Total		Total		Total	<u> </u>	Total	Γ	Total		Total
			,	Date:		Date:	==::)ate:		Date:	·	Date: _	<u> </u>	Date:	
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				Re-Exam		Re-Exam	2	Re-Exam	3	Re-Exam	4	Re-Exa	m 5	Re-Exam	6
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Yes		No							ĺ						
Yes		No	Do you have foul smelling, yellow or greenish			-									
Yes		No	Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase?				,								
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	ıotal	DOX.		Date:	Total	Date:	Total	Date:	Total	Date:	Total	Date:	Total	Date:	Total
	Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No Yes No	Yes No Do you feel bloated or irritable around ovulation? Does it feel as if your ovulation lasts longer than it should? Do you experience nipple pain or discharge from your nipples? Have you been diagnosed with elevated prolactin No levels? No Are your menses painful? Do you feel your menstrual cramps in the external No genital area? Is the menstrual blood thick and dark, or purplish No in color? Total Boxes Checked Do you break out with red acne (especially premenstrually)? No Do you have a short menstrual cycle? Yes No Do you have vaginal irritation or rashes? Yes No Do you have fibrocystic breasts? No Do you have foul smelling, yellow or greenish No vaginal discharge? Are you prone to vaginal and/or rectal itching Yes No Total Boxes Checked	Yes No Do you feel bloated or irritable around ovulation? Does it feel as if your ovulation lasts longer than it should? Do you experience nipple pain or discharge from your nipples? Have you been diagnosed with elevated prolactin No levels? Yes No Are your menses painful? Do you feel your menstrual cramps in the external genital area? Is the menstrual blood thick and dark, or purplish No in color? Total Boxes Checked Date: P Re-Exam 1 Re-Exam 1 Po you break out with red acne (especially premenstrually)? Yes No Do you have a short menstrual cycle? Yes No Do you have vaginal irritation or rashes? Yes No Do you have fibrocystic breasts? Yes No Do you have foul smelling, yellow or greenish No vaginal discharge? Are you prone to vaginal and/or rectal itching No during your luteal or premenstrual phase? Total Boxes Checked	Yes No Do you feel bloated or irritable around ovulation? Does it feel as if your ovulation lasts longer than it No should? Do you experience nipple pain or discharge from No your nipples? Have you been diagnosed with elevated prolactin No levels? Yes No Are your menses painful? Do you feel your menstrual cramps in the external No genital area? Is the menstrual blood thick and dark, or purplish No in color? Total Boxes Checked Do you break out with red acne (especially No premenstrually)? Yes No Do you have a short menstrual cycle? Yes No Do you have vaginal irritation or rashes? Yes No Do you have fibrocystic breasts? Yes No Do you have foul smelling, yellow or greenish No vaginal discharge? Are you prone to vaginal and/or rectal itching No during your luteal or premenstrual phase? Total Boxes Checked Total Boxes Checked Total	Total Boxes Checked PO you break out with red acne (especially premenstrually)? No Do you break out with red acne (especially premenstrually)? No Do you have rogulariant on rashes? No Do you have rogularian and/or rectal itching your poxes and enter curre receivant of your nipples? Have you been diagnosed with elevated prolactin No levels? No Are your menses painful? Do you feel your menstrual cramps in the external yenital area? Is the menstrual blood thick and dark, or purplish in color? Total Boxes Checked Po you break out with red acne (especially premenstrually)? No Do you have vaginal irritation or rashes? Yes No Do you have fibrocystic breasts? Yes No Do you have foul smelling, yellow or greenish No vaginal discharge? Are you prone to vaginal and/or rectal itching No during your luteal or premenstrual phase? Total Boxes Checked Total Total Total Total Total Total Total Total	FOR LONG TERM PATIENTS ON LONGER pertain to you, or if your your boxes and enter current date. Yes No Do you feel bloated or irritable around ovulation? Does it feel as if your ovulation lasts longer than it should? Do you experience nipple pain or discharge from your nipples? Have you been diagnosed with elevated prolactin No levels? Yes No Are your menses painful? Do you feel your menstrual cramps in the external No genital area? Is the menstrual blood thick and dark, or purplish No in color? Total Boxes Checked Do you break out with red acne (especially premenstrually)? Yes No Do you have a short menstrual cycle? Yes No Do you have vaginal irritation or rashes? Yes No Do you have fold smelling, yellow or greenish No vaginal discharge? Are you prone to vaginal and/or rectal itching No during your luteal or premenstrual phase? Total Boxes Checked Total Total Total Total Total Total	POR LONG TERM PATIENTS ONLY: On LONGER pertain to you, or if you HAVE NO your boxes and enter current date. Yes No Do you feel bloated or irritable around ovulation? Does it feel as if your ovulation lasts longer than it No should? Do you experience nipple pain or discharge from your nipples? Have you been diagnosed with elevated prolactin No levels? Yes No Are your menses painful? Do you feel your menstrual cramps in the external you genital area? Is the menstrual blood thick and dark, or purplish No in color? Total Boxes Checked Do you break out with red acne (especially permenstrually)? Yes No Do you have a short menstrual cycle? Yes No Do you have a short menstrual cycle? Yes No Do you have daylinal irritation or rashes? No Do you have giplic pressts? Yes No Do you have giplic pressts? Yes No Do you have fibrocystic breasts? Yes No Do you have followed smelling, yellow or greenish No vaginal discharge? Are you prone to vaginal and/or rectal itching No during your luteal or premenstrual phase? Total Boxes Checked Total Date: Total Total Total Total Total Total Total Total	POR LONG TERM PATIENTS ONLY: On the day'd LongER pertain to you, or if your HAVE NOT expert your boxes and enter current date. Re-Exam 1 Re-Exam 2 Re-Exam 3 Yes Do you sperience nipple pain or discharge from No your nipples? Have you been diagnosed with elevated prolactin No levels? Yes No Are your menses painful? Do you feel your menstrual cramps in the external No genital area? Is the menstrual blood thick and dark, or purplish No in color? Total Boxes Checked Do you break out with red acne (especially No premenstrually)? Yes No Do you have a short menstrual cycle? Yes No Do you have vaginal irritation or rashes? Yes No Do you have folious melling, yellow or greenish No vaginal discharge? Are you prone to vaginal and/or rectal itching No during your luteal or premenstrual phase? Total Boxes Checked Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total Total	POR LONG TEXM PATIENTS ONLY: On the day of your rectangle LONGER pertain to you, or if you HAVE NOT experienced the your boxes and enter current date. 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Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 1 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 2 Re-Exam 3 Re-Exam 4 Re-Exam 3 Re-Exam 4 Re-Exam 4 Re-Exam 4 Re-Exam 4 Re-Exam 4 Re-Exam 4 Re-Exam 4 Re-Exam 4 Re-Exam 5 Re-Exam 4 Re-Exam 5 Re-Exam 4 Re-Exam 5 Re-Exam 6 Re-Exam 6 Re-Exam 6 Re-Exam 6 Re-Exam 7 Re-Exam 7 Re-Exam 7 Re-Exam 8 Re-Exam 8 Re-Exam 8 Re-Exam 8 Re-Exam 8 Re-Exam 9 Re-Exam 9 Re-Exam 9 Re-Exam 1 R	FOR LUNG TERM PATIENTS ONLY: On the day of your re-exam only check the box LONGER pertain to you, or if you HAVE NOT experienced the symptoms for two week your boxes and enter current date. No	FUR LONG I ERRIM PATIENTS VOIL.** On the day of your re-exam only check the boxes that I Dose and not your boxes and not possed and not your boxes and not your boxes and not possed and not your boxes and not your boxes and not possed and not your boxes and not possed and not your boxes and not possed and not your boxes and not possed and not your boxes and not possed and not possed and not your boxes and not possed and not possed and not possed and not your boxes and not possed and not possed and not possed and not your boxes and not possed