TAO OF HEALTH

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To assist in providing you with the best possible care, please fill out this form as accurately as you can. All the information will be kept confidential in your file.

Name: _____

Today's date: _____ Date of birth: _____ Age: _____

How old were you when you had your first menstruation? _____ Years old.

Date last menses began? _____

Is your cycle: □ Regular □ Often Early
□ Irregular □ Often Late

Cycle length (i.e. 28 days)? _____ How many days do you bleed? _____

Do you spot or bleed outside your normal flow? □ Yes □ No
If yes, then when: □ Mid cycle
□ Before start of period
□ End of period

Describe your flow? □ Heavy □Light □Average

What color is the blood? □ Pink □ Bright Red
□ Dark Red □ Purple
□ Brown □ Black

Consistency of blood? □ Watery/thin □ Average □ Thick

Does your menstruation contain clots? □ Yes □ No
At what point during the cycle? □ Start □ Middle □ End
What size are the clots? □ Large □ Small

Do you experience menstrual pain? □ Yes □ No
At what point during the cycle □ Before (menses)
□ During*
□ After
*If during, what days? (I.e. days 2 & 3) _____

What type of pain is it? □ Stabbing □ Dull
□ On & off □ Cramping □ Heavy
What relieves the pain? (i.e. pressure, cold, heat) _____

Do you experience nipple sensitivity or discharge? □ Yes □ No

Do you experience Pre-menstrual Symptoms (PMS)? (Check all that apply)
□ Breast tenderness □ Cramps □ Acne □ Change in bowel movements
□ Bloating □ Headaches □ Nausea □ Moodiness
□ Fatigue □ Disturbed Sleep
List any other premenstrual symptoms. _____
_____
_____

Do you notice a difference in energy or fatigue around your menses? (More energy / fatigue)
□ Before □ During □ After □ N/A

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Do you experience pain around ovulation? □ Yes □ No

Do you notice cervical mucous around time of ovulation? □ Yes □ No
Quality: □ Stretchy & Clear □ White □ Dry

Do you ovulate on your own? □ Yes □ No

Do your breasts get tender at/during ovulation □ Yes □ No

Anything else you would like to mention about menstruation please do so here: _____
_____
_____
_____

Have you taken oral contraceptives? □ Yes □ No
How long? _____
When did you stop? _____

Have you ever had an IUD? □ Yes □ No
How long? _____

Have you ever taken Depo-Provera? □ Yes □ No
If yes, When was the first shot? _____
Is it a 3 month cycle, or 6 month cycle? _____
Have you noticed any abnormal side effects since starting Depo-Provera? _____
_____
_____

Do you experience excess vaginal secretions (discharge)? □ Yes □ No
Colour: □White □ Yellow □ Greenish □ Pinkish □ Red
Consistency: □ Watery □ Thick □ Sticky
Odour: □ Normal □ Unpleasant □ Foul

How many times have you been pregnant? _____

How many times have you given birth? _____
Ages of children _____
How many miscarriages? _____
How many weeks pregnant? _____ What year(s)? _____

How many times has a D&C been performed? _____

Any abortions? □ Yes □ No What year(s)? _____

Were there any problems during or after any of these pregnancies? □ Yes □ No
If yes, Please Explain: _____
_____
_____
_____
_____

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Date of last Pap smear: _____/____/____ (MM/DD/YY)

Have you ever had an abnormal pap smear?	☐ Yes ☐ No
Have you ever had a cervical biopsy, operation, and/or cauterization?	☐ Yes ☐ No
Do you get yeast infections regularly?	☐ Yes ☐ No
Do you get bladder infections (UTI's) regularly?	☐ Yes ☐ No
Have you ever been diagnosed with Chlamydia infection?	☐ Yes ☐ No
Have you ever had pelvic inflammatory disease?	☐ Yes ☐ No

Were you treated for it? How? _____
_____
_____

Have you ever been diagnosed with:

Uterine fibroids?	☐ Yes ☐ No
Polyps?	☐ Yes ☐ No
Pelvic adhesions?	☐ Yes ☐ No
Prolapsed uterus?	☐ Yes ☐ No
Pelvic abnormalities?	☐ Yes ☐ No
Endometriosis	☐ Yes ☐ No
PCOS (polycystic Ovarian Syndrome)	☐ Yes ☐ No

Additional comments or questions:

_____
_____
_____
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