Name: ________________________

Date: ________________________

WOMEN'S HEALTH FORM

How old were you when you had your first menstruation? __________ years old

Date of last menstruation? __________________ Is your cycle: ___ Regular ___ Irregular ___ Often Early ___ Often Late

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

Number of pregnancies ___________ Number of live births ____________ Ages of children __________________

Were there any problems during or after any of these pregnancies? ___Yes ___No

If yes:

Please specify: ____

Please describe your labours____

____

____

Were there any postpartum complications or illnesses? ___Yes___No

If yes, please explain____

____

Have you had any miscarriages? ___Yes___No

If yes, please list details ____

____

____

Have you had any abortions? ___ Yes___ No

Are you pregnant? ___Yes ___No

Are you breastfeeding? ___Yes ___No

Do you spot or bleed outside your normal flow? ___ Yes___ No

If yes:

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

What is the consistency of blood? ___ Watery/thin ___ Average ___Thick

Does your menstruation contain clots (larger than a nickel)? ___ Yes ___ No

If yes:

At what point during the cycle? ___ Start ___ Middle___ End

What size are the clots? ___ Large ___Medium ___ Small

Do you experience menstrual pain? ___ Yes ___ No

If yes:

At what point of the cycle? ___ Before ___ 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
___ Other ____

Do you notice a difference in energy or fatigue around your period? (More energy / fatigue)

More energy:

___ Before ___During ___After ___N/A

More fatigue:

___ Before ___During ___After ___N/A

Do you experience pain around ovulation? ___Yes ___No

Do you notice cervical mucous around time of ovulation? ___Yes ___No

If yes:

Quality: ___Stretchy & Clear ___White ___Dry

Do you ovulate on your own? ___Yes ___No

Comments regarding ovulation/menstruation:

____

____

____

Have you taken oral contraceptives? ___Yes ___ No

If yes:

How long were you taking them? _____________________________

When did you stop (mm/dd/yyyy)? ______________________________

Have you ever had an IUD? ___ Yes ___ No

If yes:

How long? _____________________________

Have you ever taken Depo-Provera? ___ Yes ___ No

Do you experience excess vaginal secretions (discharge)? ___ Yes ___ No

If yes:
Color: ___White ___Yellow ___Greenish ___ Pinkish ___ Red
Consistency: ___Water ___ Thick ___Sticky
Odor: ___ Normal ___Unpleasant ___ Foul

What was the date of your last Pap smear (mm/dd/yyyy) ______________________________
Have you ever had an abnormal pap smear? ___ Yes ___ No

If yes:
What were the abnormal results? ____

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 regularly? ___Yes ___ No

Have you ever been diagnosed with Chlamydia infection? ___Yes ___ No
Have you ever had pelvic inflammatory disease? ___Yes ___ No

If yes:
Were you treated for it? ___Yes ___No
How? ____

Have you ever been diagnosed with any of the following?

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:
____
____
____

How long have you been trying to conceive? ____
Have either you or your partner had a diagnosis relating to infertility? ___ Yes ___ No
Have you taken medication to help you ovulate? ___ Yes ___ No

If yes:
What kind? _________________________________
For how many cycles? __________________________

Have your fallopian tubes been evaluated medically? ___ Yes ___ No

If yes:
What were the results? ____
Have you had any tubal operations? ___Yes ___ No

Have you had any hormone laboratory tests performed? ___Yes ___No

If yes:

FSH	___ Normal	___ High	
Prolactin	___ Normal	___ High	
Thyroid	___ Normal	___ High	___ Low
Progesterone	___ Normal	___ High	___ Low
Testosterone	___ Normal	___ High	___ Low
Other ______________________________	___ Normal	___ High	___ Low

Have you ever had fertility treatments? (IVF, IUI, etc.) ___ Yes ___ No

If yes:

Month/Year	Type of Treatment	Clinic
_________	_______________________________	_______________________
_________	_______________________________	_______________________
_________	_______________________________	_______________________
_________	_______________________________	_______________________
_________	_______________________________	_______________________

How did you respond to the fertility treatments? ___ Poor Response ___ Average/Good Response

Comments:

____

____

____

Do you use basal body temperature charts, ovulation sticks or saliva ferning to check your ovulation cycle?		___ Yes	___ No
Have you been exposed or received chemotherapy or radiation?		___ Yes	___ No
How is your sexual desire (mental interest)?	___ Low	___ Normal	___ High
How is your sexual arousal (physically aroused/orgasm)?	___ Low	___ Normal	___ High
Do you use vaginal lubricants?		___ Yes	___ No
Are you more than 20% over your ideal body weight?		___ Yes	___ No
Are you more than 20% below your ideal body weight?		___ Yes	___ No
Do you have excessive facial/body hair?		___ Yes	___ No
Do you have excessive oily skin?		___ Yes	___ No
Have you experienced excessive loss of head hair?		___ Yes	___ No

You have now completed the Women's Health Form for Body In Balance Acupuncture. Please make sure to fill out the General Health History Questionnaire. Please bring both forms to your initial assessment. Thank you.