MARIN ACUPUNCTURE CLINIC

Women's Health Intake

Age of first menses: Date of last menstrual period: Usual # of days bleeding:

Blood clots: yes no when: Usual length between cycles (i.e. 28 days):

Color of menstrual blood: (please circle) pale bright red dark red brown other _____

Texture of menstrual blood: thick thin watery normal

Pain/Cramps: yes no when:

Irregular periods (describe):

PMS: moodiness breast tenderness bloating constipation other_____

Current method(s) of contraception: Past method(s) of contraception:

Are you currently pregnant? yes no Are you trying to get pregnant? yes no

Number of pregnancies: Number of live births:

Number of miscarriages: Number of abortions: Any premature births:

Breast (lumps, cysts, tenderness, etc.):

Urinary tract infections: How frequent?

Vaginal infections/ discharges (describe color and/or smell):

Pain/itching of genitalia:

Date of last Pap smear: Pap smear: normal abnormal

Date of last mammogram: Mammogram: normal abnormal

Uterine fibroids: Endometriosis: PID: Other:

Menopause (date of onset): Symptoms: Any bleeding since?

Are you currently on Hormone Replacement Therapy (HRT)? yes no Dose:

How long have you been on HRT? Any side effects?

Anything else we should know about your gynecological history?

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