

For Women:

How old were you during your first menstrual period? _____

Do you currently have regular menstrual periods? Yes No When was your last period? _____

If no, when and why did menstruation end? _____

If you are currently having menstrual periods

Is your cycle regular? Yes No Typical number of days/weeks in your cycle _____

Do you have menstrual clots? Yes No Do you have pain during your cycle? Yes No

Is the color of your flow:

- pale red
- dark red
- bright red
- purplish

Is the amount of the flow:

- light
- moderate
- heavy
- extremely heavy

Is your cycle pain:

- before flow
- during flow
- after flow

Pain location: _____

If pain, is it relieved by

- heat?
- cold?
- pressure?

If pain, is it aggravated by

- heat?
- cold?
- pressure?

The pain is

- dull sharp, stabbing
- a burning sensation
- a bearing down sensation

Do you have bleeding between periods? Yes No Have you had any C-sections? Yes No

Do you currently use birth control? Yes No Recurring yeast infections? Yes No

If yes, what type of birth control? _____

How many children? _____ How many pregnancies? _____

Have you had a hysterectomy? Yes No Total Partial

History of abnormal PAP smears? Yes No If yes, please explain: _____

Do you experience specific emotions around your period?

- depression sadness anger irritability other: _____

Other hormonal symptoms experienced:

- | | | |
|--|--|--|
| <input type="checkbox"/> symptoms occur in a monthly pattern | <input type="checkbox"/> vaginal discharges | <input type="checkbox"/> hot flashes |
| <input type="checkbox"/> diminished or increased sexual desire | <input type="checkbox"/> PID (Pelvic Inflammatory Disease) | <input type="checkbox"/> fibroids |
| <input type="checkbox"/> painful intercourse or orgasm difficulty | <input type="checkbox"/> inability to conceive | <input type="checkbox"/> ovarian cysts |
| <input type="checkbox"/> pain, discomfort or itching in genital area | <input type="checkbox"/> other: _____ | |

For Men:

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> diminished sex drive | <input type="checkbox"/> prostate problems | <input type="checkbox"/> infertility |
| <input type="checkbox"/> diminished mood, energy, motivation | <input type="checkbox"/> sores or rashes in genital area | <input type="checkbox"/> hernia |
| <input type="checkbox"/> decreased muscle mass, increased body fat | <input type="checkbox"/> pain, lump, or mass in testicle | Other: _____ |
| <input type="checkbox"/> erectile dysfunction | <input type="checkbox"/> discharge from penis | |