This page is for FEMALES ONLY:

Age period began: _____
Regularity of period: _____
Duration of period: _____
Pain/Cramps: _____none _____prior to period _____during period _____after period
Intensity of pain/cramps: _____great _____moderate _____light
Color of menstrual blood: _____light _____medium _____dark
Menstrual flow: _____has clots _____fishy odor _____rotten odor _____is heavy _____is light
Non-menstrual bleeding/spotting: _____No _____Yes
Water weight gain/bloating: _____prior to period _____during period _____after period
Other physical/emotional changes related to cycle:
Check which birth control methods used and how long you've used them:
_____abstinence _____IUD _____condom _____condom with foam or jelly
_____diaphragm _____diaphragm with foam or jelly _____spermicides
_____rhythm _____pill _____withdrawal _____other: _____
Vaginal Discharge: _____No _____Yes Color: _____ Odor: _____
Vaginal Infections: _____Past _____Present How treated: _____
Have you ever been pregnant? _____No _____Yes Number of Times: _____
Number of children living? _____
Condition of newborns: _____ healthy _____premature _____jaundice _____late _____other
Have you ever miscarried: _____No _____Yes Number of Times: _____
Have you ever had abortions? _____No _____Yes Number of Times: _____
Other complications related to pregnancy: _____
Have you gone through menopause: _____Yes _____No If so, when:_____
Other remarks regarding OB/GYN history:_____