

MENSTRUAL HISTORY Name _____ Date _____

1. What age did your period start? _____
2. What were your periods like as a teenager and into your 20's?
 - a. Heavy? Yes / No, any clots at all (even if not heavy)? Yes / No
 - b. Length of cycle: Every _____ days, lasting _____ days.
 - c. Pain? Yes / No On a scale of 0-10, 0 being no pain, and 10 being the worst? _____ did you have to miss school or work? Yes / No
3. What are your periods like now, or if not having periods what were they like just before they stopped?
 - a. Heavy? Yes / No, any clots at all (even if not heavy)? Yes / No
 - b. Length of cycle: Every _____ days, lasting _____ days.
 - c. Pain? Yes / No On a scale of 0-10, 0 being no pain, and 10 being the worst? _____ did you have to miss school or work? Yes / No
4. How many days (or weeks) before your period do/did you know you're having your period? _____
 - a. Any signs or symptoms at all: such as - **BLOATING** Yes / No, **WATER WEIGHT GAIN** Yes / No, **HEADACHE** Yes / No, **IRRITABILITY / MOODINESS** Yes / No, **WEEPINESS** Yes / No, **DIARRHEA** Yes / No, **BREAST TENDERNESS** Yes / No, **BACK PAIN** Yes / No
5. Have you ever been pregnant? Yes / No
 - a. If so, how many times? _____
 - b. How many live births? _____
 - c. How many miscarriages? _____
6. Did you have problems getting pregnant? Yes / No
 - a. If so, describe the problem as you understand it:

7. If you have ever been pregnant, how did you feel during the pregnancy? And during which trimester did you feel the best?

MENOPAUSE

1. If you are menopausal, at what age did your periods stop completely? _____
2. At what age did your period start to slow down or show other signs of change? _____
3. Did you have a hysterectomy? Yes / No
 - a. If so, what kind?
 - i. Total abdominal hysterectomy? Yes / No
 - ii. Partial hysterectomy (just the uterus)? Yes / No
 - b. If so, why did you have a hysterectomy?
 - i. Heavy bleeding? Yes / No
 - ii. Fibroid uterus? Yes / No
 - iii. Endometriosis? Yes / No
 - iv. Cancer? Yes / No, Precancer? Yes / No
4. When you became menopausal what symptoms did you have?
 - a. Hot flashes? Yes / No
 - b. Poor sleep? Yes / No
 - c. Increased aches and pains? Yes / No
 - d. Decreased memory / concentration? Yes / No
 - e. Moodiness? Yes / No
 - f. Vaginal dryness? Yes / No
 - g. Dry skin or mouth? Yes / No

5. Have you taken any medications for menopause? Yes / No Any hormone replacement?
Yes / No
- If so, what kind? _____
 - If so, when and for how long? Start _____ End _____ or Currently
6. Did these hormones alleviate all of the above symptoms? Yes / No
- If not all, then which symptoms do/did you still have while taking the hormones?

7. While on hormone replacement therapy, did you have any breast, cervical, or uterine biopsies or abnormalities of your mammogram or any other tests? Yes / No
- If so, please describe the occurrence and the year when it happened:

8. What menopausal symptoms do you have now?
- Hot flashes? Yes / No
 - Poor sleep? Yes / No
 - Increased aches and pains? Yes / No
 - Decreased memory / concentration? Yes / No
 - Moodiness? Yes / No
 - Vaginal dryness? Yes / No
 - Dry skin or mouth? Yes / No
 - Other symptoms? Yes / No _____
9. Has any first-degree relative (mother, sister) had breast cancer, uterine cancer, or cervical cancer? Yes / No
- If yes, please list whom, what kind, and at what age these occurred:

10. Has any second-degree relative (aunt, first cousin, grandparent) had breast cancer, uterine cancer, or cervical cancer? Yes / No
- If yes, please list whom, what kind, and at what age these occurred:

