WOMEN'S INTAKE

Name

Current Age

Age when menses started

Age when Menopause started (if applicable, circle all that apply if currently experiencing menopause symtoms.)____________________

Hot flashes, vaginal dryness, loss of sex drive, night sweats, low energy, mood swings, poor memory

Date of last menstrual cycle

Average length of cycle

Average days of flow

PMS (circle all that apply)

sore breasts, bloated, fatigue, cravings, emotional, cramping

Other:

Menstruation (circle all that apply)

cramping, bloated, fatigue, craving, emotional, headaches, clots, spotting, digestion issues

Other:

Are you periods (circle all that apply)

Heavy, light, painful, irregular

Color of menstrual blood (circle all that apply) If fluctuate, mark all that apply.

Pale/light red. Red, Bright red, Dark Red , Dark red/brown

Have you been diagnosed with any of the following (circle all that apply)

Endometriosis, PCOS, PID, Infertility, Prolapse, UTI

Other:

# of pregnancies

# of children

# of miscarriages/abortions

Reproductive health

Surgeries

Birth control

HRT

NHRT/Progesterone cream

Immediate family member with breast, uterine or ovarian cancer

Fibroid tumors or ovarian cysts

Abnormal Pap

Date of last Pap test

Signature____

Date____