Do not write, stamp, punch holes or affix a sticker in this area.

Direction of Feed

Menstrual History

Please answer every question

To reproduce, follow the printing instructions. Do not fold this form.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

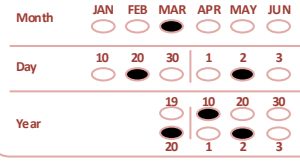
PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH Month Day Year

Age at first menstrual period: 7 8 9 10 11 12 13 14 15 16 17

Date of last menstrual period:

EXAMPLE
If your last period started on March 22nd, 2012 you would fill in:



Month: JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

Day: 10 20 30 1 2 3 4 5 6 7 8 9

Year: 19 20 10 1 20 2 30 3 40 4 50 5 60 6 70 7 80 8 90 9

How certain are you of this date? very certain somewhat certain uncertain

How many days do your menstrual cycles last? 0 10 1 20 2 30 3 40 4 50 5 60 6 70 7 80 8 90 9

Number of days between menstrual cycles: 0 10 1 20 2 30 3 40 4 50 5 60 6 70 7 80 8 90 9

Description of flow: light medium heavy

Do you have blood clots? yes no

Do you have breakthrough bleeding? yes no

Average number of tampons used: 0 10 1 20 2 30 3 40 4 50 5 60 6 70 7 80 8 90 9

Average number of pads used: 0 10 1 20 2 30 3 40 4 50 5 60 6 70 7 80 8 90 9

Are you on hormone replacement therapy? yes no

CONTRACEPTIVE METHODS (mark only one)

over-the-counter, condom, Depo-Provera©, diaphragm, IUD, pill, cervical cap, rhythm, sterilization, withdrawal, tubal ligation, vasectomy, other, NONE

PREGNANCY TEST

Office Test: blood positive, blood negative, blood equivocal, urine positive, urine negative, urine equivocal, NO TEST

Home Test: positive, negative, NO TEST

MENOPAUSE

premenopausal, perminepausal, postmenopausal

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SAMPLE

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