

CLIENT HEALTH HISTORY FOR WOMEN ONLY

Your Menstrual Pattern:

- Painful periods
- Late, early, or irregular
- Dark, thick blood at onset or end of menstruation
- Dizziness with period
- Headache or migraine with period
- Excessive bleeding (more than one pad per hour)
- Blood clots during menstruation
- PMS/Depression with or before period
- Failure to ovulate regularly
- Painful ovulation
- Bloating or water retention with period

Do you experience heaviness in the lower pelvis **as menses begin**? _____

Do you experience heaviness in the lower pelvis **during ovulation**? _____

How many days does your period last? ____ Do you experience NO periods at all? _____

Explain _____

Have you experienced a period every two weeks within the past few years? _____

Have you taken hormone replacement therapy? ____ If so, for how long? _____

Check other signs or symptoms that apply:

- | | |
|--|------------------------------|
| Varicose veins of the legs ____ | Tired weak legs ____ |
| Numb legs and feet especially when standing still ____ | Sore heels when walking ____ |
| Constipation ____ | Painful intercourse ____ |
| Low back ache ____ | Hot flashes ____ |
| Cervical polyps ____ | Mood swings ____ |
| Uterine polyps ____ | Memory loss ____ |
| Uterine fibroids ____ | Depression ____ |
| Uterine infections ____ | Difficult menopause ____ |
| Frequent urination ____ | Bladder infections ____ |
| Vaginal discharge ____ (color/how often?) _____ | Insomnia ____ |
| Vaginal yeast conditions/vaginitis ____ | Fatigue ____ |
| Chronic miscarriages ____ | Spotting ____ |
| Premature deliveries ____ | Pelvic inflammation ____ |
| Weak newborn infants ____ | Ovarian or breast cysts ____ |
| False pregnancies ____ | Endometriosis ____ |
| Difficult pregnancy, "incompetent" uterus ____ | Endometritis ____ |
| Sexually transmitted disease ____ | |

Dry vagina with or without menopause _____
Cancer of the cervix, uterus, bladder, or lower bowel (circle) _____
List any other symptoms not included on list: _____
How many pregnancies have you had? _____ Number of deliveries? _____
Date(s) of deliveries _____ How many children? _____
Were there any complications? _____
What was pregnancy like for you? _____
labor? _____
delivery? _____
Did you nurse your babies? _____
If so, what was your impression of that experience? _____
Have you had any miscarriages? _____ Have you had any abortions? _____
If so, how many and when _____
What medications did your mother take when she was pregnant with you? _____

Do any of the **women on your mother's side of the family** suffer from any of the following:
Fertility issues _____ Menstrual problems _____ Difficult childbirth _____
Difficult menopause _____ Cancer _____ Heart trouble _____

Please list any serious falls or accidents in childhood or as an adult especially those that involved your tailbone, back, head, or any whiplash – please explain: _____

Are you now or have you ever taken birth control pills? _____
When and for how long? _____
If any, what type of birth control methods do you currently use? _____
Do you now or have you ever had fertility challenges? _____

Are you presently or have you recently been under a doctor's care for gynecological problems?
Explain _____

Rate your interest in sex: High _____ Moderate _____ Low _____ None _____
Do you have difficulty achieving orgasms? _____ Explain _____
Were you ever raped? _____ At what age did this occur? _____
Are you a survivor of incest? _____ Have you undergone counseling for rape or incest? _____
What was that like for you? Did it help? _____

SUPPLEMENTS

Please list any supplements, herbs, vitamins, or natural products you are presently taking:

