West County Spine & Joint
Chiropractic Clinic

Menstrual History Questionnaire

To help complete your medical history, please complete the following information as accurately as possible. Some of these questions deal with personal information. Please be assured that your answers will remain confidential.

Name: _____
Date: _____
Sport: _____

1. Have you been to an OB-GYN before? YES NO If YES, date of last pap smear: _____

2. Approximate date/age of first menstrual period: _____

3. When was your last period? _____

4. If your periods have been irregular and/or infrequent and can remember all approximate dates, please list the cycle dates: _____
_____
_____

5. How often have you had menstrual periods in the last year?
_____ Once every 20 days or less
_____ Every 21-27 days
_____ Every 28-35 days
_____ Every 36-50 days
_____ Every 3-4 months
_____ Very irregular, sometimes monthly, sometimes skip several months
_____ Other (Please specify) _____

6. My periods usually last _____ days.

7. Number of periods in the last 12 months _____

8. What is the longest you have gone without having a menstrual period? _____

9. My menstrual flow is usually: _____ light _____ moderate _____ heavy

10. Do you have bleeding between periods? _____ YES _____ NO

11. Do pain and cramping accompany your menstrual cycle? ___ not at all ___ slightly ___ a great deal

12. If yes, do you (check all that apply):
___ Take Pain Medication
___ Lose time from school, job or other function
___ Function less efficiently at school, job, home or sport
___ Reduce your level of physical exercise/training
___ Miss practice/workout days
___ Continue workout days but decrease training level
___ Continue life with little change

13. Do you think vigorous exercise/training effects your menstrual periods? ___ YES ___ NO
If yes, please explain these changes: _____
_____

14. Have you ever seen a medical practitioner about problems associated with your period? ___ YES ___ NO
If yes, what did they tell you? _____
_____

15. Do you consider yourself
___ Underweight
___ Slightly Underweight
___ Just right
___ Slightly overweight
___ Overweight

16. Have you ever experienced significant weight loss or gain? ___ YES ___ NO
If yes, please explain: _____
_____

17. In the past year, has your weight:
___ Basically stayed the same (varied 1-5 pounds)
___ Increased
___ Decreased

18. In the past year, has your sport activity/training:
___ Basically stayed the same
___ Increased
___ Decreased
If it has increased or decreased, please explain: _____
_____

19. Do you have a history of stress fractures? ___ YES ___ NO

20. Have you experienced any injuries the past year? If so, please describe: _____
_____
_____
_____

21. Do you currently have any problems that you feel influence your diet? _____
_____
_____

22. Is your diet well balanced? ___ YES ___ NO

23. Do you now or have you ever experienced (for each checked, please add details to explain):
Irregular menstrual periods _____
Absent menstrual periods _____
Cold intolerance _____
Tingling sensation in hands or feet _____
Headaches _____
Lightheadedness/Dizziness _____
Fainting _____
Change in energy _____
Change in urinary function/# of times urinating a day _____
Sleeping difficulties _____
Skin changes _____
Hair loss _____
Hair growth on face and/or chest _____
Chest pains _____
Rapid heart beat _____
Shortness of breath _____

Mood swings _____
Episodes of crying for "no reason" _____
Frequently thinking about food _____
Confusion _____
Difficulty concentrating _____
Anxiety, especially around food _____
Less social interaction with family _____
Frequently tired _____
Memory problems _____
Difficulty making decisions _____
Problems with teeth _____
Sore throat _____
Swollen parotid glands _____
Taste changes _____
Constipation _____
Diarrhea _____
Muscle pain _____
Joint pain _____
Obsessive-compulsive behaviors _____
Feelings of depression _____
Other (explain) _____

24. Please list current medication/supplement intake:
Prescription Medication: _____
Vitamins: _____
Minerals: _____
Herbs: _____

25. *When in doubt, the more information Dr. Lauren has, the better we can understand the "whole picture" of you! It is her goal to help you be a happy, healthy and active person for your entire life. Together, we can work towards that goal! Your health is YOURS, and we are here to help. If there is anything else you would like Dr. Lauren to know, or if you would like to elaborate more on one of the above questions, please feel free to do so in the open space below.*

Food Frequency Checklist

Patient Name:

Date:

Please check the frequency the following foods are consumed:
***** If there are foods NOT on this list that you consume, please add them to the bottom of the list.***

	Never or Less than Once per week	1-2 times per week	3-7 times per week	More than Once a day
Fresh Vegetables				
Canned Vegetables				
Fresh Fruits				
Canned Fruits				
Beef				
Sausage, Bacon, Lunchmeat				
Pork				
Poultry				
Poultry – Prebreaded, e.g. nuggets				
Poultry – Fried				
Fish				
Fish – Prebreaded, e.g. fish sticks				
Fish – Fried				
Shellfish				
Beans				
Peanut Butter				
Pizza				
Milk (Specify Type)				
Cream				
Cheese				
Cheese – Regular				
Cheese – Low Fat				
Cheese – Non-Fat				
Yogurt (regular or greek)				
Ice Cream				
Frozen Yogurt				
Eggs				
Oils				
Butter				
Margarine				
Candy				
White Bread				
Wheat Bread				
Cereal/Oatmeal				
Granola Bars				
White Pasta				
Whole Wheat Pasta				
White Rice				
Brown Rice				
Water				
Regular Soda				
Diet Soda				
Fruit Juice				