LOTUS CENTER OF ORIENTAL MEDICINE - WOMEN'S HEALTH SCREEN

Name _____ Birth Date ___/___/_____ Today's Date ___/___/_____

Current health problems/concerns: _____

_____

Current medications, prescription (i.e. hormones) or over-the-counter _____

General Health (check any that apply):

Chronic fatigue ___ Irritability ___ Shortness of breath ___ Headaches ___ Bone pain ___ Memory fails ___

Have you experienced unintentional weight loss or gain of 10 pounds or more in the last three months _____

Gynecological History:

Date of last gynecological exam (PAP, mammogram) ____ Results _____

Date of last menstrual cycle ___/___/_____ Length of cycle _____ Interval of time between cycles _____

Any recent changes in normal menstrual flow _____ Age at first period _____

Form of birth control _____ Number of children _____ Number of pregnancies _____

C-section _____ Surgical menopause date ___/___/___

Describe Surgery _____

Endometriosis ___ Infertility ___ Fibrocystic Breasts ___ Fibroids/Ovarian Cysts ___ Reproductive cancer ____

Pelvic Inflammatory Disease ___ Vaginal Infections ___ Vaginal Candidiasis ___ Genital Herpes ___ SID _____

Family Medical History (check any that apply):

Breast or other cancers ___ Cardiovascular disease ___ Osteoporosis ___ Obesity ___ Alcoholism ___

Mental Illness/Depression ___ Alzheimer's ___ Diabetes ___ Arthritis ___ Stroke ___

Lifestyle & Diet:

Rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest) _____

Identify the major causes _____

Do you eat (check any that apply):

Sweets, sodas, ice cream ____ Fried foods ____ Whole grains, legumes, cereals ____ Fruits, vegetables ___

List your 4 favorite foods _____

Do you (check any that apply):

Diet frequently ___ Skip meals ____ How many meals do you eat per day _____ Dine out regularly _____

Use tobacco/smoke cigarettes _____ How many cigarettes per day ____ Exposed to passive smoke ____

Drink coffee _____ # cups per day ____ Strong ____ Mild ____ Decaffeinated ____ Eat Chocolate ____

Drink alcoholic beverages ___ How many ounces per day/per week ___ Preference _____

Exercise daily ___ How many times per week/activity _____

Do you restrict your intake of or avoid completely (check all that apply):

Dietary fat ___ Dairy products ___ Animal protein ___ Salt ___ Fiber ____ All animal foods ____

Check the symptoms you experience regularly one to two weeks before your period:

Part 1

1. ____ Anxiety
2. ____ Irritability
3. ____ Nervous tension
4. ____ Aggressive or hostile toward family/friends
5. ____ Engage in self destructive behavior
6. ____ Weight gain
7. ____ Water retention
8. ____ Abdominal bloating
9. ____ Tender, swollen and/or painful breasts
10. ____ Breast lumps increase in size and tenderness
11. ____ Discharge from nipples
12. ____ Craving for sweets
13. ____ Increased appetite
14. ____ Heart palpitations
15. ____ Fatigue
16. ____ Headaches
17. ____ Shaky or clumsy
18. ____ Depressed
19. ____ Withdrawn
20. ____ Confused
21. ____ Forgetful
22. ____ Insomnia/difficulty sleeping

Check the symptoms and/or behaviors that occur during your period with a frequency or intensity that affects your daily activities:

Part 2

1. __ Cramping in lower abdomen or pelvic area
2. __ Sharp intermittent pain
3. __ Dull aching pain
4. __ Upset stomach
5. __ Diarrhea
6. __ Nausea or vomiting
7. __ Low back aches
8. __ Headaches
9. __ Difficulty Concentrating
10. __ Accident prone
11. __ Unusual fatigue (take naps)
12. __ Decreased productivity
13. __ Weight gain
14. __ Painful and/or swollen breasts
15. __ Irritability
16. __ Mood swings
17. __ Depression
18. __ Painful intercourse

Check off any of the following statements that describe your menstrual cycle, energy level or reproductive function:

Part 3

1. __ Heavy prolonged menstrual bleeding/clotting
2. __ Menstrual bleeding that lasts longer than 5 days
3. __ Absence of periods for 3 months or more
4. __ Vaginal itching, burning, dryness
5. __ Menstruation that occurs too frequently (every 21-24 days)
6. __ Irregular periods (once every three to six months)
7. __ Frequently skip periods
8. __ Menstrual cycle every 36 days or longer
9. __ Unusually light or heavy periods
10. __ Unusually light menstrual flow -"spotting"
11. __ Menses last three days and are light
12. __ Bleeding or spotting between periods
13. __ Bleeding between periods is light -"spotting"
14. __ Bleeding between periods is heavy and/or clots
15. __ Abnormal vaginal discharge
16. __ Frequent urination

Check any of the following symptoms if they occur throughout the month with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself:

Part 4

1. __ Decline of vital energy and sense of well-being
2. __ Hot flashes
3. __ Night sweats
4. __ Spontaneous sweating
5. __ Chills
6. __ Depressed
7. __ Irritable
8. __ Anxiety
9. __ Anger
10. __ Mood swings
11. __ Headaches
12. __ Forgetful
13. __ Difficulty concentrating
14. __ Difficulty sleeping
15. __ Urinary problems
16. __ Vaginal problems
17. __ Dry skin
18. __ Bleeding between periods
19. __ Irregular periods
20. __ Stopped menstruating
21. __ Joint and muscle pain
22. __ Change in sexual desire
23. __ Difficulty with orgasm
24. __ Painful intercourse
25. __ Loss of muscle tone
26. __ Vaginal bleeding any time
27. __ Vaginal bleeding after sex
28. __ Vaginal discharge

Additional Comments:

_____

_____

_____

_____

_____