

Female Health

Age when periods began:	Day 1 of your last period:	Age (if/when) periods ended:
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Dates of pregnancies:	Dates of miscarriages or terminations:
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Usual length of a cycle:	Cycle length variation in the last year:
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Usual length of periods:	If you get 'spotting', when does it occur?
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Have your cycles or periods changed recently?	
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Premenstrual symptoms

Typical timeframe:		
Do you get? <input type="checkbox"/> Irritable <input type="checkbox"/> Vulnerable <input type="checkbox"/> Weepy <input type="checkbox"/> Clumsy	<input type="checkbox"/> Tired <input type="checkbox"/> More energy <input type="checkbox"/> Breast distension/heaviness <input type="checkbox"/> Headaches <input type="checkbox"/> Bloating	<input type="checkbox"/> Breast pain <input type="checkbox"/> Lumpy breasts <input type="checkbox"/> Lower abdominal pain <input type="checkbox"/> Other symptoms

Period pains

Location: <input type="checkbox"/> Lower abdomen <input type="checkbox"/> Lower back <input type="checkbox"/> Thighs <input type="checkbox"/> Elsewhere	Nature: <input type="checkbox"/> Fixed <input type="checkbox"/> In waves <input type="checkbox"/> Cramping <input type="checkbox"/> Stabbing	<input type="checkbox"/> Bloating <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Dragging
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Better/Worse

Are pains eased by: <input type="checkbox"/> Heat <input type="checkbox"/> Resting <input type="checkbox"/> Moving <input type="checkbox"/> Pressure <input type="checkbox"/> Painkillers	Are pains worse with: <input type="checkbox"/> Cold <input type="checkbox"/> Resting <input type="checkbox"/> Moving <input type="checkbox"/> Pressure <input type="checkbox"/> Stress
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The Period

Menstrual blood changes in colour, quantity and thickness

Day	Quantity: light-heavy (1-5)	Colour: bright/ normal/dark red	Clot sizes: 5p, 20p, 50p, ++, stringy	Consistency: watery/thin/thick	Pain: (0-5)
1					
2					
3					
4					
5					
6					
7+					

Ovulation pain <input type="checkbox"/> Minor/none <input type="checkbox"/> Dull <input type="checkbox"/> Dragging <input type="checkbox"/> Sharp <input type="checkbox"/> Heavy	Mucus/discharges: <input type="checkbox"/> Thin/watery <input type="checkbox"/> Creamy <input type="checkbox"/> Yellow/green/brown <input type="checkbox"/> Causes discomfort <input type="checkbox"/> Other problems
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