GLENVIEW HEALING ARTS CENTER

FEMALE QUESTIONAIRE

Name:____ Date:_________________

Age Menstrual Cycle started:______________ Age stopped:________________

Have you completed Menopause? ____yes ____no

Please check or explain if applicable

- ❑ Irregular ___________________________________
- ❑ Painful ___________________________________
- ❑ Excessive bleeding ___________________________________
- ❑ Lack of blood ___________________________________
- ❑ Dark color ___________________________________
- ❑ Pale color ___________________________________
- ❑ Clotting ___________________________________
- ❑ Water retention ___________________________________
- ❑ Painful breasts ___________________________________

Abnormal Vaginal Discharge

- ❑ Liquid ___________________________________
- ❑ Yellow ___________________________________
- ❑ Thick ___________________________________
- ❑ Bad odor ___________________________________
- ❑ White ___________________________________
- ❑ Other ___________________________________

Gynecological history or operations ______________________

- ❑ Hormonal Imbalance ________________________________
- ❑ Ovaries ___________________________________
- ❑ Tubes ___________________________________
- ❑ Vaginal ___________________________________
- ❑ Breast ___________________________________
- ❑ Other ___________________________________

Last menstrual period?_______________________

Are you or might you be pregnant?_____If yes, how many weeks?_____

Are you using birth control? _____ if so, what method(s) _____________________

Are you experiencing reduced sexual energies?_______________

Other difficulties____

Do you have regular pap tests?______ Date of last PAP_____________**Pregnancy**:

Total number of pregnancies?______________________________

Number of children? _______Their ages?____________________

Number of miscarriages? _______Number of abortions?________

Complications?____