OC Acupuncture | Dr. Nazanin Rohani, L.Ac., MSOM
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Gynecological History — Confidential

Please complete this form as accurately as you can. All the information will be kept confidential.

Name: ____

Today's Date: ______________ Date of birth: ___________________ Age: _____
(MM/DD/YY) (MM/DD/YY)

How old were you when you had your first menstruation? ____________ Years old.

Date last menses began? ____________ Is your cycle: □Regular □ Irregular □ Often Early □ Often Late

Cycle length (i.e. 28 days)? ___________ How many days do you bleed? __________

Do you spot or bleed outside your normal flow? □Yes □No
If yes, then when: □Mid cycle □Before start of period □End of period

Describe your flow? □Heavy □Light □Average

What color is the blood? □Pink □Bright Red □Dark Red □Purple □Brown □Black

Consistency of blood? □Watery/Thin □Average □Thick

Does your menstruation contain clots? □Yes □No

At what point during the cycle? □Start □Middle □End

What size are the clots? □Large □Small

Do you experience menstrual pain? □Yes □No

At what point during the cycle? □Before (menses) □During* □After *If during, What days? (i.e. days 2 & 3) _____________

What type of pain is it? □Stabbing □Dull □On & off □Cramping □Heavy

What relieves the pain? (i.e. pressure, cold, heat) ____________________________________
Medications? ______________________

Do you experience nipple sensitivity or discharge? □Yes □ No

Do you experience Pre-menstrual Symptoms (PMS)? (Check all that apply)
□ Breast tenderness □Cramps □Acne □Change in bowel □movements
□Bloating □Headaches □Nausea □Moodiness □Fatigue □Disturbed Sleep

List any other premenstrual symptoms below.

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Gynecological History (Continued)

Is there a difference in energy or fatigue around your menses? (More energy / fatigue)

☐ Before ☐ During ☐ After ☐ N/A

Do you experience pain around ovulation? ☐ Yes ☐ No

Do you notice cervical mucous around time of ovulation? ☐ Yes ☐ No

Quality: ☐ Stretchy & Clear ☐ White ☐ Dry

Do you ovulate on your own? ☐ Yes ☐ No

Do your breasts get tender at/during ovulation? ☐ Yes ☐ No

Anything else you would like to mention about menstruation please do so here:

Have you taken oral contraceptives? ☐ Yes ☐ No

How long? _____________ When did you stop? _______________

Have you ever had an IUD? ☐ Yes ☐ No

How long? _____________

Have you ever taken Depo-Provera? ☐ Yes ☐ No

Do you experience excess vaginal secretions (discharge)? ☐ Yes ☐ No

Color: ☐ White ☐ Yellow ☐ Greenish ☐ Pinkish ☐ Red

Consistency: ☐ Watery ☐ Thick ☐ Sticky

Odor: ☐ Normal ☐ Unpleasant ☐ Foul

Number of pregnancies? ________________________

Number of births? _____________________________ Ages of children _____________________

Miscarriages? _____________ How many weeks pregnant? ________ What year(s)? ________

Any D&C Surgery? ☐ Yes ☐ No How many? _______________

Any abortions? ☐ Yes ☐ No Year(s)? ________________

Any problems during or after any of these pregnancies? ☐ Yes ☐ No

Gynecological History (Continued)

Date of last Pap smear: _______/_______/_______ (MM/DD/YY)

Any abnormal pap smears? ☐ Yes ☐ No

Had a cervical biopsy, operation, and /or cauterization? ☐ Yes ☐ No

Regular yeast infections? ☐ Yes ☐ No

Bladder infections (UTI's) regularly? ☐ Yes ☐ No

Have you ever been diagnosed with:

- Uterine fibroids? ☐ Yes ☐ No
- Pelvic inflammatory disease? ☐ Yes ☐ No
- Polyps? ☐ Yes ☐ No
- Pelvic adhesions? ☐ Yes ☐ No
- Prolapsed uterus? ☐ Yes ☐ No
- Pelvic abnormalities? ☐ Yes ☐ No
- Endometriosis? ☐ Yes ☐ No
- PCOS (Polycystic Ovarian Syndrome) ☐ Yes ☐ No
- Chlamydia infection? ☐ Yes ☐ No

Were you treated for it? ☐ Yes ☐ No How? ____

Additional comments or questions:

 Please print and complete. Be sure to bring with you to your appointment.