Avicenna Acupuncture
www.avicennadenver.com

3411.W.38th.Ave
Denver, CO 80211
Phone: 303 803 0675

Women's Health History - Confidential

Patient name: _____

Age at which menses began _____ How many days do you normally bleed? _____

Your bleeding is? Light ☐ Normal ☐ Heavy ☐

What color is the blood? Light red ☐ Red ☐ Dark red ☐ Purple ☐ Brown ☐ Black ☐

Is there clotting? Yes ☐ No ☐

Are your menstrual cycles spaced regularly? Yes ☐ No ☐

How many days are there from one period to the next? Yes ☐ No ☐

Do you bleed or spot between periods? Yes ☐ No ☐

Have your cycles changed since they began? Yes ☐ No ☐

How? _____

How many days does the pain last? _____

Are your periods painful? Yes ☐ No ☐

Do you have a **pre**menstrual tension? Yes ☐ No ☐

Do your breasts become tender **pre**menstrually? Yes ☐ No ☐

Do you get premenstrual low back pain? Yes ☐ No ☐

Are your bowel movements loose at the beginning of your period? Yes ☐ No ☐

How many pregnancies have you had? _____ How many children do you have? _____

How many abortions have you had? _____ How many miscarriages have you had? _____

How many times D&C been performed? _____

Have you ever had a cervical biopsy, cauterization or conization? Yes ☐ No ☐

Do you get yeast infections often? Yes ☐ No ☐

Do you have vaginal discharge? Yes ☐ No ☐

Do you have any sores on your genitalia? Yes ☐ No ☐

Have you ever had pelvic inflammatory disease? Yes ☐ No ☐

Were you treated for it? Yes ☐ No ☐

How? _____

Date of last Pap smear _____

Have you ever been diagnosed with uterine fibroids or polyps? Yes ☐ No ☐

Have you ever been diagnosed with endometriosis? Yes ☐ No ☐

Have you been diagnosed with pelvic adhesions? Yes ☐ No ☐

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

Do you have pain or cramping during ovulation? Yes ☐ No ☐

Have you, or are you currently going through menopause? Yes ☐ No ☐

If yes, please list your symptoms:

Symptom	Onset	Medications

How is your sexual energy?

Low ☐ Normal ☐ High ☐

Do you have excessive facial hair? Yes ☐ No ☐

Do you have excessively oily skin? Yes ☐ No ☐

Have you experienced excessive loss of head hair? Yes ☐ No ☐

Have you been exposed to any known environmental toxins or hormones?

Yes ☐ No ☐