Chameleon Acupuncture & Wellness

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Gynaecology form (Female patients only)

Menses History

Date last menses began	dd/mm/yyyy	
Is your menstrual cycle	Regular	
	Irregular	
How old where you when you had your first menstruation?		
Menstrual cycle length (i.e. 26-30 days)		

Contraceptive history

Have you taken oral contraceptives? **Y/N**
For how long?
When did you stop?

Pre-menstrual symptoms (PMS)

Please check all that apply

Breast tenderness	
Cramps	
Acne	
Change in bowel	
Nausea	
Headaches	
Moodiness	
Fatigue	
Night sweats	
Sleep disturbances	

Please list any other pre-menstrual symptoms

Menses

Describe your flow	Heavy	
	Light	
	Average	
Consistency of blood	Watery	
	Thick	
	Average	
	Clotty	
Colour	Red	
	Dark red	
	Brown	
	Brown/red	
	Bright red	
Do you experience any Spotting?	Y/N	
For how many days?		
Do you experience menstrual pain?	Y/N	
Before menses, during or after?	Pain type?	
	Stabbing	
	Cramping	
	Dull	
	Heavy	
	On / off	
What relieves the pain?		

Ovulation

Do you ovulate on your own?	**Y/N**

What Day?		
Ovulatory pain	**Y/N**	
Mastitis	**Y/N**	
Do you chart your cycle?	**Y/N**	
BBT		
Ovulation sticks		
Saliva		
Do you notice stretchy, clear, egg white, cervical mucus around ovulation?	**Y/N**	
Do you experience vaginal discharge?	**Y/N**	
Colour		
White		
Yellow		
Green		
Pinkish		
Red		
Consistency		
Watery		
Thin		
Thick		
Sticky		
Odour		

Pregnancies
Births

Menopause

Age started?
Age finished?
Symptoms
Medication (HRT/how long)?

Please check if you have ever been diagnosed with

An STD	
Uterine fibroids	
Pelvic adhesions	
Unique shaped uterus	
Polyps	
Prolapsed uterus	
Endometriosis	

If yes please provide details

Have you ever had an abnormal pap smear? (Date of last pap smear) **Y/N**
Have you ever had a cervical biopsy or operation? **Y/N**
Do you get yeast infections regularly? **Y/N**
Have you had any hormone lab tests performed? (Test and level) **Y/N**