STEPHEN D. SAEKS, PhD, LAc
2 Roads Crossing Healthcare, PC
15455 NW Greenbrier Parkway, Suite 240
Beaverton, Oregon 97006-8116
503-617-0450

MENSTRUAL CYCLE QUESTIONNAIRE

Today's Date: _____

NAME:_____ **AGE**: _____ **DOB**:_____

1. At what age did you have your first period? _____
2. On the average, how long is your monthly cycle (from menses to menses)? _____
3. Are your monthly cycles regular (same length) every time? **Y** **N**
4. How long does your period last? _____
5. What color is the blood? _____
   _____
6. Do you experience clotting? **Y** **N** If yes, please describe the size, color and amount of clots you typically have. _____
   _____
7. Do you have painful periods (***if NO, go to # 13***) **Y** **N**
8. The onset of the pain is: **Before** **During** After my period. (circle all that apply)
9. The pain gets **Better** or **Worse** with pressure. (circle one)
10. Heat makes the pain feel **Better** or **Worse**. (circle one)
11. Below is a list of terms that describe the pain. Please circle all that apply.

    Burning **Cramping** **Stabbing**
    Pulling **Bearing Down (before period)** **Bearing Down (after period)**
    Decreases after passing clots **Distension with pain**

Please complete both sides of this form

12. Below is a list of areas in which the pain might be located. Please circle all that apply.

    Both sides of the lower abdomen Left side Right Side

    In the middle of the lower abdomen

    Goes back to/towards the tail bone/lower back

Please circle the time frame(s) that apply in questions 13-16

13. Do you experience any breast tenderness before, after or during your period? **Y N**

14. Do you experience any breast swelling or distension before, after or during your period? **Y N**

15. Do you ever get any nausea or vomiting before, during, or after your period? **Y N**

16. Do you experience any mood changes before, after, or during your period? **Y N**

17. Below is a list of moods, feelings, experiences. Please circle all of those that apply from question 15.

Mood changes (frequently) (rapidly)	**Sad**	**Angry**
Irritable/short fused	**Overly happy/upbeat**	**Clumsiness**
Aggressive	**Agitated**	**Weepiness**
Tired	**Dizzy**	**Poor Memory**

18. Do you take Birth Control Pills? **Y N** If yes, what brand? _____

19. Have you had any gynecological surgeries or procedures? **Y N** If yes, please list them below with the approximate dates of the procedures:

    _____

    _____

    _____

Thank you for completing this form.