Restorative Acupuncture

Gilian Lata, LAc, Dipl OM

Name: _____

Primary GYN: _____

MENSTRUAL/HORMONAL

1. Age at which menses began: ___ 2. Did you have any problems? ( ) yes ( ) no If yes, please explain:

_____

3. Date of last two menstrual periods: __/__/__ and __/__/

4. Do your periods come at regular intervals? ( ) yes ( ) no

5. How many days do you normally bleed? _____

6. How many days from onset to onset? _____

7. How heavy is the bleeding? ( ) Light ( ) Medium ( ) Heavy

8. Do you bleed or spot between periods? ( ) yes ( ) no

9. What color is the blood? ( ) Light Red ( ) Red ( ) Dark Red ( ) Purple ( ) Brown ( ) Black

10. Is there clotting? ( ) yes ( ) no

11. Do you have premenstrual tension? ( ) yes ( ) no

( ) Irritability ( ) Low Back Pain ( ) Constipation ( ) Diarrhea ( ) Cramping
( ) Water Retention ( ) Cravings ( ) Acne ( ) Breast Tenderness

12. If you have any of these symptoms, when in the cycle do they occur and for how long? _____

_____

13. Are your periods painful? ( ) yes ( ) no If so, when and how long does it last? _____

_____

14. Have you had any of the following?

( ) Hot Flashes
( ) Breast discharge
( ) Visual Disturbance
( ) Chronic Headache
( ) Increased facial/body hair
( ) Vomiting
( ) Weight Increase > 10 pds
( ) Weight Decrease < 10 pds
( ) Extraordinary Stress
( ) Excessive loss of head hair

15. If yes, please explain: _____

_____

PREGNANCY HISTORY

1. Pregnancies __ 2. Term Births __ 3. Premature Births __ (what week) 4. Miscarriages __ (# of weeks) 5. Elective Abortion __

Date	Miscarriage	Elective Abortion	D&C	Ectopic Pregnancy	Months to Conceive	Infertility Treatment	Weight & Sex	C-Section	Complications	Is current partner the father?

CONTRACEPTION USE

Type	From When to When	Reason discontinued

GYNECOLOGICAL

1. Have you ever had an abnormal pap smear? ( ) yes ( ) no 2. Date of last pap smear? _____

3. Do you get yeast infections regularly? ( ) yes ( ) no 4. Do you douche regularly? ( ) yes ( ) no

5. Have you had an STD (sexually transmitted disease)? ( ) yes ( ) no

If yes, what was it and how was it resolved? _____

6. Do you have chronic vaginal discharge? ( ) yes ( ) no

7. Do you have any sores on your genitalia ( ) yes ( ) no

8. Have you ever had a cervical biopsy, operation, cauterization, or freezing (cryo)? ( ) yes ( ) no If so, please explain: _____

9. Have you ever had pelvic inflammatory disease (PIV)? ( ) yes ( ) no

10. If yes, were you treated for it? ( ) yes ( ) no How? _____

11. Have you ever been diagnosed with uterine fibroids or polyps? ( ) yes ( ) no

12. Have you ever been diagnosed with endometriosis? ( ) yes ( ) no

13. Have you ever been diagnosed with pelvic adhesions? ( ) yes ( ) no

14. Have you ever been diagnosed with any pelvic abnormalities? ( ) yes ( ) no

15. Have you ever been diagnosed with PCOS (Polycystic Ovarian Syndrome)? ( ) yes ( ) no

16. Have you ever been diagnosed with LUFTS (Luteinized Unruptured Follicle Syndrome)? ( ) yes ( ) no

17. How is your sexual energy? ( ) Low ( ) Normal ( ) High

18. Do you use vaginal lubricants? ( ) yes ( ) no