

**Lotus Center LLC**  
410 Ramapo Valley Road  
Oakland, NJ 07436  
201 - 337 - 0220

**FEMALE PATIENTS**

**Menstruation:**

Age of first period \_\_\_\_\_ Date and result of the most recent Pap exam \_\_\_\_\_

First day of most recent period \_\_\_\_\_ Length between periods \_\_\_\_\_ Birth Control \_\_\_\_\_

Age of last period (menopause) \_\_\_\_\_ Any difficulties with menopause? \_\_\_\_\_

Regularity of period:

- Regular  Irregular  Usually early  Usually late  Varies between being early or late  
by \_\_\_ days by \_\_\_ days

How many days of menstrual flow do you usually have? \_\_\_\_\_

- Flow is typically:  Heavy  throughout  first few days  last few days  
 Moderate  throughout  first few days  last few days  
 Light  throughout  first few days  last few days

Color is typically:  Pale pink  Red  Bright red  Dark red  Purplish  Brownish

Consistency is typically:  Thin  Thick  Clotted

Discomfort with period:

- Abdominal bloating  before  during  after menstruation  
 Lower back soreness  before  during  after menstruation  
 Cramping/pain  before  during  after menstruation  
 Other \_\_\_\_\_

Premenstrual Syndrome (PMS):

- Irritability  Bloating  Mood swings  Breast tenderness  Water retention  
 Other \_\_\_\_\_

Other symptoms related to menses:

- Vaginal dryness  Headache  Nausea  Diarrhea  Constipation  Insomnia  
 Ravenous appetite  Poor appetite  Night sweats  Hot flashed  Higher libido  Lower libido

Vaginal Discharge:

- No  Yes If yes, color, amount, odor, itching: \_\_\_\_\_

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Bleeding between cycles:  none  comes on suddenly  all the time  occasional spotting  
Color \_\_\_\_\_ Amount \_\_\_\_\_

Breast: Abnormal nipple discharge:

No  Yes If yes, color: \_\_\_\_\_

Have you ever been diagnosed with:

Fibroids  Fibrocystic Breast  Endometriosis  Ovarian Cysts  PID  PCOS  
 Gonorrhea  Syphilis  Chlamydia  Herpes  HIV  HPV

Type of Contraception you use: \_\_\_\_\_

Pregnancy:

Are you currently pregnant?  Yes  No  Not sure

Number of: Pregnancies \_\_\_\_\_ Live births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Terminations \_\_\_\_\_

Please list note any difficulties during the pregnancy and/or after delivery (for example: morning sickness, edema, prolonged bleeding after delivery, gestational diabetes, high blood pressure, fever postpartum, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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