Name:_____ Date_____

Gynecology - Part 1a

Primary Complaint: PMS - Irregular Cycles - Painful Menses - Other

Instructions: There are seven (7) pages of 'Fill-In' pdf forms. Please provide as much information as possible - this is your opportunity to tell me what has been occurring in the past, your current condition as well as concerns you have for your future should this condition continue.

Name your Primary Complaint: ☐ Premenstral Syndrome ☐ Irregular Cycles ☐ Painful Menses
☐ Spotting or Excessive Flow ☐ Vaginal discharge ☐ Excess clots ☐ Other_____

Indicate all abnormalities or exacerbated conditions that occur simultaneously with your Primary Complaint:

☐ Balance	☐ Appetite	☐ Blood pressure	☐ Energy	☐ Addiction	☐ Fertility
☐ Hearing	☐ Defecation	☐ Arrythmias	☐ Libido	☐ Attitude change	☐ Pain (physical)
☐ Smell	☐ Digestion	☐ Angina	☐ Menses	☐ Behavior change	☐ Twitching-Tics
☐ Speech	☐ Thirst	☐ Breathing	☐ Vaginal fluids	☐ Cravings	☐ Hiccups
☐ Swallowing	☐ Urination	☐ Skin	☐ Semen flow	☐ Emotions	☐ Self Esteem
☐ Taste	☐ Bleeding	☐ Hair	☐ Sleep	☐ Mental function	☐ Self Image
☐ Touch	☐ Mucus flow	☐ Nails	☐ Excess naps	☐ Memory	☐ Motivation
☐ Vision	☐ Swelling			☐ Pain (from emotions)	

Is this your first time seeking treatment for the primary complaint? ☐ Yes ☐ No, I have sought _____ prior.
No. of times

When did the primary complaint become disruptive to your ADL, caused significant impairment or prompted treatment?

_____
How many days, weeks, months or years ago or the date.

When did the primary complaint or associated symptoms begin before the condition became disruptive to your Activities of Daily Living or caused significant impairment?

_____
Indicate the number of days, weeks, months or years or the date.

How frequently does the primary complaint or associated symptoms interfere with Activities of Daily Living?

_____
Indicate number of minutes, hours in a day or number of days/weeks

What do you think is the origin or cause of the primary complaint? _____

_____

What provides relief to the primary complaint? _____

_____

_____

_____

Please answer the following:

Are you willing to have blood tests?	☐ No	☐ Yes	☐ Unknown
Do you have paniful intercourse?	☐ No	☐ Yes	☐ Unknown
Do you have excessive bloating?	☐ No	☐ Yes	☐ Unknown
Do you retain excess water?	☐ No	☐ Yes	☐ Unknown
Can you stop OC for 120-180 days?	☐ No	☐ Yes	☐ Unknown
Are you lactose intolerant?	☐ No	☐ Yes	☐ Unknown
Are you gluteomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Are you caseomorphin reactive?	☐ No	☐ Yes	☐ Unknown
Do you have a food allergy?	☐ No	☐ Yes	☐ Unknown
Are you on prescription medication?	☐ No	☐ Yes	
Are you taking OTC medicines? Are	☐ No	☐ Yes	
you taking illicit drugs?	☐ No	☐ Yes	
Are you taking herbs?	☐ No	☐ Yes	
Do you smoke tobacco?	☐ No	☐ Yse	

If you need to include more information, write it in a MSWord documents and title it with your name and Primary Complaint. Example: John_Doe_Repro & Urogen Gynec - PMS - Irregular Cycles - Painful Menses Part 1a

Name: _____ Age_____ Date_____

Gynecology - Part 1b

Primary Complaint: PMS - Painful Menses - Irregular Cycle - Other

Are you pregnant now?	☐Yes.☐No.☐Maybe:
Date of last menstrual period?	/ / Date of menarche: / /
Duration of nature flow: (please indicate daily flow quantity & color) **Flow:** ☐Light ☐Normal ☐Heavy **Color:** ☐Light brown☐Normal ☐Brown ☐Purple ☐ ☐Bright red ☐Light red/pink ☐Very dark ☐	Day 1: Day 2: Day 3: Day 4: Day 5: Day 6: Day 7: Bleeding/spotting between periods?
Blood clots:	☐Yes.☐No. When:
Length of cycle:	
Texture of menstrual blood:	☐Thick☐Thin☐Watery☐Normal☐Other:
Pain:	☐Yes.☐No. When:
Irregular periods?	(please describe)
Pre-menstrual syndrome (PMS)?	(please describe)
Current method of contraception:	
Past method of contraception:	
Number of pregnancies:	
Number of live births:	
Number of miscarriages:	
Number of abortions:	
Any premature births:	
Breasts:	☐Lumps ☐Cycts ☐Tenderness ☐Other:
Urinary tract infections (UTI):	☐Yes.☐No. How frequent?
Vaginal infections/discharges:	(describe color and nature)
Pain/itching of genitalia:	
Pap smear:	☐Normal.☐Abnormal. Date of last Pap smear: / /
Uterine fibroids:	
Endometriosis:	
Menopause:	Date of onset? Symptoms: Any bleeding since?
Are you currently on hormone replacement therapy? (HRT)	☐Yes.☐No. Dose: How long have you been on HRT? Any side effects?
Other:	

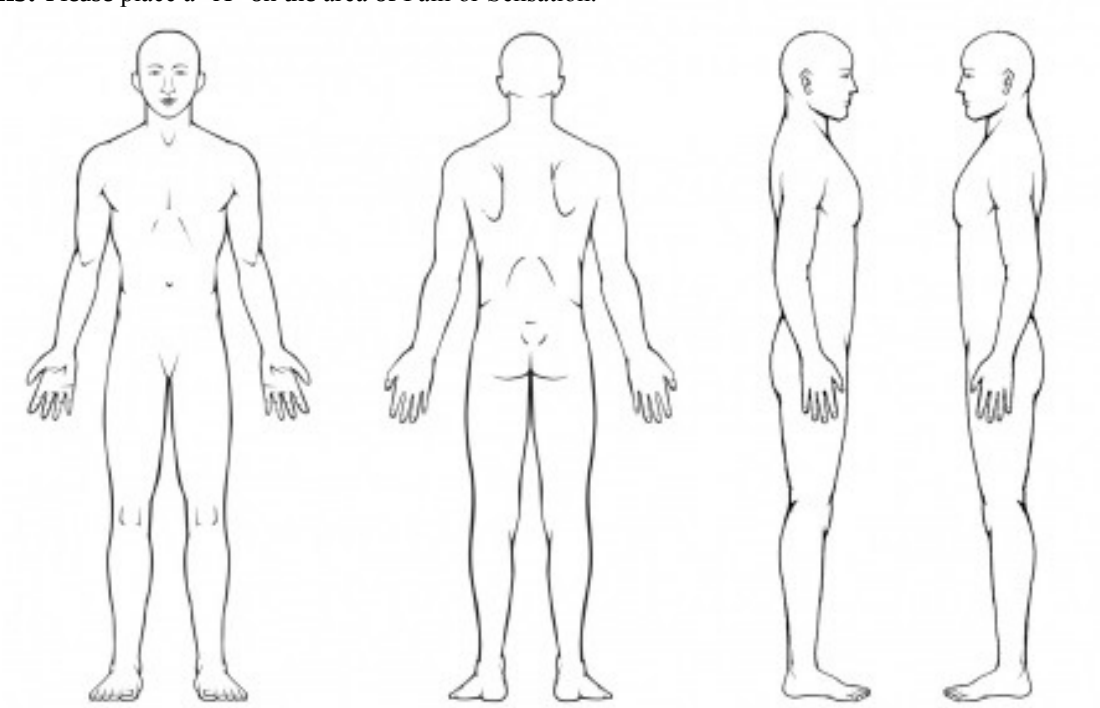
Submit any additional information in a MSWord Document with the filename as Your name & CC_10 Gynecology
Example: Jane_Doe_CC_10_Gynec_Part 1b

Name:_____ Date_____

Gynecology - Part 1c

Primary Complaint: PMS - Irregular Cycles - Painful Menses - Other

Instructions: Please place a "X" on the area of Pain or Sensation.



Front Rear Right Left

Type of Pain or Sensation:

- ☐ Sharp
- ☐ Shooting
- ☐ Throbbing
- ☐ Burning
- ☐ Dull
- ☐ Aching
- ☐ Tingling
- ☐ Numbness
- ☐ Cramping
- ☐ Tightening
- ☐ Stiffness
- ☐ Swelling
- ☐ Heat
- ☐ Cold
- ☐ Crawling
- ☐ Itching

Quality.of Primary Complaint:

- ☐ Constant ☐ Fixed
- ☐ Intermittent ☐ Moving

Trigger or Aggrivated by:

- ☐ Cold ☐ Heat
- ☐ Physical activity
- ☐ Emotional upset
- ☐ Stress ☐ Weather

Rate your pain at it's most and least painfulness:

- ☐ 0 None
- ☐ 1 Mild - nagging, annoying, interferes little with ADLs
- ☐ 2 Mild - nagging, annoying, interferes little with ADLs
- ☐ 3 Mild - nagging, annoying, interferes little with ADLs
- ☐ 4 Moderate - Interfere's significantly with ADLs
- ☐ 5 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 6 Moderate - Interfere's significantly with ADLs & need OTC med
- ☐ 7 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 8 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 9 Severe - Disabling, unable to perform ADLs & Need Rx med
- ☐ 10 Severe - Disabling, unable to perform ADLs & Need hospital

Are you hands or feet too sensitive to touch? ☐ Yes ☐ No
Does it hurt at night when bed covers touch? ☐ Yes ☐ No
Do your symptoms worsen at night? ☐ Yes ☐ No
Do your legs feel weak when you walk? ☐ Yes ☐ No
Do your legs/feet hurt when you walk? ☐ Yes ☐ No
Are your feet skin dry and crack open? ☐ Yes ☐ No
Can your feet discern hot/cold water in tub/shower? ☐ Yes ☐ No
Do your legs/feet experience 'asleep feeling' or loss of sensation? ☐ Yes ☐ No
Are you unable to sense you feet when you walk? ☐ Yes ☐ No
Do you have sharp, stabbing or shooting pain in our feet? ☐ Yes ☐ No

What provides relief of Pain or sensation?_____

_____

_____

_____

_____

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Repro & Urog Gynec Part 1c

Name:_____ Date_____

Use the next four (4) pages to embellish upon the details of your PAIN and Life Experiences.

Gynecology - Part 2

Primary Complaint: PMS - Irregular Cycles - Painful Menses -

Other

Instructions: The Day your Gynecology Issue became disruptive to your ADL or caused significant impairment

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order starting with the morning of and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012. Then describe the following:

- where you were located when you noticed the Gynecology Issue (or a medical diagnosis that was given),
- how you felt and any emotional responses
- what ADL you could not do or what bodily functions were significantly impaired
- the duration of the Gynecology Issue and characteristics (qualities)
- anything that seemed to make it worsen or improve it
- any observations by other people of your behavior, emotions or physical condition

Date your Gynecology Issue or associated symptoms became disruptive to your ADL or caused significant impairment:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Gynec Part 2

Name:_____ Date_____

Gynecology - Part 3

Primary Complaint: PMS - Irregular Cycles - Painful Menses - Other

Instructions: Your Life Prior to the Day the Gynecology Issue became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back to the earliest date when you noticed the Gynecology Issue and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your Gynecology Issue became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moving your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarceration institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date of earliest recall of Gynecology Issue or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Gynec Part 3

Name:_____ Date_____

Gynecology - Part 4

Primary Complaint: Gynec - PMS - Irregular Cycles - Painful Menses - Other

Instructions: Your Life 1 year Prior to the Earliest Date you noticed the Gynecology Issue or associated symptoms cited in Part 3.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Reflect back 1 year prior to the earliest date when you noticed the Gynecology Issue and/or associated symptoms. Please identify the date. This does not have to be an exact calendar date – it can be 'mid-November 2011', or sometime in the summer of 2009, or it might be as specific as the morning of New Year's Day 2012.
- Next, list the events of your life that occurred between that earliest date of symptoms and the day your PAIN became disruptive to your ADL or caused significant impairment. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Date 1 year prior to the earliest recall of the Gynecology Issue or associated symptoms:

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Gynec Part 4

Name:_____ Date_____

Gynecology - Part 5

Primary Complaint: Gynec - PMS - Irregular Cycles - Painful Menses - Other

Instructions: Your Symptoms and Actions since the day your Gynecology Issue or associated symptoms became disruptive to your ADL or caused significant impairment cited in Part 2.

Please include what was indicated on Part 1 along with details that you were not able to include. It is not necessary to write an essay - write your story in a list format. Keep it in chronological order and write brief short statements or just a few words. Do the best you can to describe your experience and the relevance or impact.

- Describe to best of you abilities the chronological sequences of the following starting from the Day the Gynecology Issue or associated symptoms became disruptive to your ADL or caused significant impairment through to today. Include the following:
  - changes of the symptoms over time (duration, intensity, improvements, worsening, etc)
  - the actions you have employed to treat the problem via MD, ND, DO, DC, LAc, PT and other therapists as well as home remedies. Include the diagnosis, therapies, medications and natural remedies (herbs, homeopathy, nutritional) that have been used. Include any and all improvements or worsening of the problem/condition due to any of the actions you employed.
- Include the events of your life that occurred during this tme period. These events include:
  travel in or outside the USA or Canada moved your home changing jobs marriage divorce separation pregnancy miscarriage abortion death of a friend, relative or pet financial stresses legal matters child rearing problems children leaving home for college child custody illness accidents incarcerated institutionalized natural disaster crime victim domestic violence or abuse substance abuse other
- Any observations by other people of your behavior, emotions or physical condition

Symptoms and Actions since the Gynecology Issue or associated symptoms became disruptive to ADL or causative to significant impairment.

If you need to include more information, write it in a MSWord documents and title it with your name and Chief Complaint.
Example: John_Doe_Gynec Part 5