____

Name (Last, First, Middle) Date

Age at which menses began ________

Are your periods painful? _Yes _No

How many days do you normally bleed? ________

How heavy is the bleeding? _Light _Normal _Heavy

What color is the blood? _Light red _Red _Dark red _Purple _Brown _Black

Is there clotting? _Yes _No

Does your face break out before or during your period? _Yes _No

Do your breasts become tender premenstrually? _Yes _No

Do you bleed or spot between periods? _Yes _No

Are your menstrual cycles spaced irregularly? _Yes _No

How many days are there from one period to the next? ________

Date of last menstrual period _________________

	Number	Years
How many pregnancies have you had?	_______	____________
How many children do you have?	_______	____________
How many abortions have you had?	_______	____________
How many miscarriages have you had?	_______	____________
How many times has a D & C been performed?	_______	____________

Have you ever had an abnormal pap smear? _Yes _No

Have you ever had pelvic inflammatory disease? _Yes _No

Were you treated for it? _Yes _No

How? ____

Date of last pap smear ________

Have you ever been diagnosed with uterine fibroids or polyps? _Yes _No

Have you ever been diagnosed with endometriosis? _Yes _No

Have you been diagnosed with pelvic adhesions? _Yes _No

Have you been diagnosed with any pelvic abnormalities? _Yes _No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	**Reason**	**How long**
___________________	____________________	____________
___________________	____________________	____________
___________________	____________________	____________
___________________	____________________	____________

__________________ ___________________ ____________

Have your cycles changed since they began? _Yes _No

How? ____

Have you ever had a cervical biopsy, operation, cauterization or conization? _Yes _No

Have you ever had a venereal disease? _Yes _No

Do you get yeast infections regularly? _Yes _No

Have you ever been diagnosed with a chlamydial infection? _Yes _No

Do you have chronic vaginal discharge? _Yes _No

Do you have any sores on your genitalia? _Yes _No

Have you had fertility treatments? _Yes _No

If yes, when and where?______________________________________

By whom? ____

What types? ____

Have you taken medication to help you ovulate? _Yes _No

When? _______ How long? _______

Have your fallopian tubes been evaluated medically? _Yes _No

What were the results? _____________________________________

Have you had any tubal operations? _Yes _No

Have you had any hormone laboratory tests performed? _Yes _No

What were the results? _____________________________________

Do you have a single partner with whom you have been trying to conceive? _Yes _No

How long have you been married or living together? _________

Has he had a fertility workup? _Yes _No

What were the results? ___________________________________

Is your partner supportive of your wish to conceive? _Yes _No

Have you taken oral contraceptives? _Yes _No When? _______ How long? _______

Have you ever had an IUD? _Yes _No When? _______ How long? _______

Have you ever taken DepoProvera? _Yes _No When? _______ How long? _______

How long have you been trying to conceive? _________________________

Have you had a diagnosis relating to infertility? _Yes _No

What was it? ____

Do you ovulate on your own? _Yes _No

On what day of your cycle? _________

Do your breasts get tender at/during ovulation? _Yes _No

Do you get premenstrual low back pain? _Yes _No

Do your bowel movements become loose at the beginning of your period? _Yes _No

How is your sexual energy? _Low _Normal _High

Do you douche regularly? _Yes _No   With what? ________________________

Do you use vaginal lubricants? _Yes _No

Are you more than 20% over your ideal body weight? _Yes _No

Are you more than 20% below your ideal body weight? _Yes _No

Do you have a stressful occupation? _Yes _No

Do you exercise regularly? _Yes _No

Do you have excessive facial hair? _Yes _No

Do you have excessively oily skin? _Yes _No

Have you experienced excessive loss of head hair? _Yes _No

Have you noticed discharge from your nipples? _Yes _No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? _Yes _No

Have you been exposed to any known environmental toxins or hormones? _Yes _No

Are you presently taking steroids? _Yes _No

Answer YES or NO to each of the following questions. Don't worry about what the symptoms mean; just note whether you experience them. If you have more than one-fourth to one-third YES responses in any diagnostic category, then you may have an element of this imbalance in your system. You may have more than one kind of imbalance operating at the same time, so don't be surprised if you have 50 percent YES answers for more than one diagnostic category.

DIAGNOSIS

KIDNEY YIN DEFICIENCY (Ki Yi-)

Do you have lower back weakness, soreness, or pain, or knee problems? _Yes _No

Do you have ringing in your ears or dizziness? _Yes _No

Does your hair prematurely gray? _Yes _No

Do you have vaginal dryness? _Yes _No

Is your midcycle fertile cervical mucus scanty or missing? _Yes _No

Do you have dark circles around or under your eyes? _Yes _No

Do you have night sweats? _Yes _No

Are you prone to hot flashes? _Yes _No

Would you describe yourself as afraid a lot? _Yes _No

Does your tongue lack coating? Does it appear shiny or peeled? _Yes _No

DIAGNOSIS

KIDNEY YANG DEFICIENCY (Ki Yan-)

Do you have lower back premenstrually? _Yes _No

Is your low back sore or weak? _Yes _No

Are your feet cold, especially at night? _Yes _No

Are you typically colder than those around you? _Yes _No

Is your libido low? _Yes _No

Are you often fearful? _Yes _No

Do you wake up at night or early in the morning because you have to urinate? _Yes _No

Do you urinate frequently, and is the urine diluted and/or profuse? _Yes _No

Do you have early morning loose, urgent stools? _Yes _No

Do you have profuse vaginal discharge? _Yes _No

Does your menstrual blood tend to be dull in color? _Yes _No

Do you feel cold cramps during your period that respond to a heating pad? _Yes _No

Is your tongue pale, moist, and swollen? _Yes _No

DIAGNOSIS

SPLEEN QI DEFICIENCY (Sp-)

Are you often fatigued? _Yes _No

Do you have poor appetite? _Yes _No

Is you energy lower after a meal? _Yes _No

Do you feel bloated after eating? _Yes _No

Do you crave sweets? _Yes _No

Do you have loose stools, abdominal pain, or digestive problems? _Yes _No

Are you hands and feet cold? _Yes _No

Is your nose cold? _Yes _No

Are you prone to feeling heavy or sluggish? _Yes _No

Are you prone to feeling heaviness or grogginess in the head? _Yes _No

Do you bruise easily? _Yes _No

Do you think you have poor circulation? _Yes _No

Do you have varicose veins? _Yes _No

Are you lacking strength in your arms and legs? _Yes _No

Are you lacking in exercise? _Yes _No

Are you prone to worry? _Yes _No

Have you been diagnosed with low blood pressure? _Yes _No

Do you sweat a lot without exerting yourself? _Yes _No

Do you feel dizzy or light-headed, or have visual changes when you stand up fast? _Yes _No

Is your menstruation thin, watery, profuse or pinkish in color? _Yes _No

Are you more tired around ovulation or menstruation? _Yes _No

Do you ever spot a few days or more before your period comes? _Yes _No

Have you ever been diagnosed with uterine prolapse? _Yes _No

Are your menstrual cramps accompanied by a bearing-down sensation in your uterus? _Yes _No

Are you often sick, or do you have allergies? _Yes _No

Have you been diagnosed with hypothyroid or anemia? _Yes _No

Do you have hemorrhoids or polyps? _Yes _No

Does your tongue look swollen, with teeth marks on the sides? _Yes _No

Do you have a pale, yellowish complexion? _Yes _No

DIAGNOSIS

BLOOD DEFICIENCY (Bl-) (*not necessarily equated with anemia*)

Are your menses scanty and/or late? _Yes _No

Do you have dry, flaky skin? _Yes _No

Are you prone to getting chapped lips? _Yes _No

Are your fingernails or toenails brittle? _Yes _No

Are you losing hair on your head (not in patches, but all over)? _Yes _No

Is your hair brittle or dry? _Yes _No

Do you have diminished nighttime vision? _Yes _No

Do you get dizzy or light-headed around your period? _Yes _No

Are your lips, the inner side of your lower eyelids, or tongue pale in color? _Yes _No

DIAGNOSIS

BLOOD STASIS (Bl X) (*often associated with blood deficiency symptoms; see Bl-*)

Is your menstrual flow ever brown or black in color? _Yes _No

Do you feel midcycle pain around your ovaries? _Yes _No

Do you have painful, unmovable breast lumps? _Yes _No

Do you experience periodic numbness of your hands and feet (especially at night)? _Yes _No

Do you have varicose or spider veins? _Yes _No

Do you have red hemangiomas (cherry red spots) on your skin? _Yes _No

Does your complexion appear dark and “sooty”? _Yes _No

Do you have chronic hemorrhoids? _Yes _No

Does your menstrual blood contain clots? _Yes _No

Have you been diagnosed with endometriosis or uterine fibroids? _Yes _No

Is your lower abdomen tender to palpation (resisting touch)? _Yes _No

Can you feel any abnormal lumps in your lower abdomen? _Yes _No

Do you have piercing or stabbing menstrual cramps? _Yes _No

Does your tongue look dark? _Yes _No

Do you have dark spots on your tongue? _Yes _No

Are the veins beneath your tongue twisty and tortuous? _Yes _No

Do you have dark spots in your eyes? _Yes _No

Have you been diagnosed with any vascular abnormality or blood clotting disorder? _Yes _No

DIAGNOSIS

LIVER QI STAGNATION (Lv Qi X)

Are you prone to emotional depression? _Yes _No

Are you prone to anger and/or rage? _Yes _No

Do you become irritable premenstrually? _Yes _No

Do you feel bloated or irritable around ovulation? _Yes _No

Does it feel as if your ovulation lasts longer than it should? _Yes _No

Are your breasts sensitive/sore at ovulation? _Yes _No

Do you experience nipple pain or discharge from your nipples? _Yes _No

Do you have a lot of premenstrual breast distension or pain? _Yes _No

Have you been diagnosed with elevated prolactin levels? _Yes _No

Do you become bloated premenstrually? _Yes _No

Are your pupils usually dilated and large? _Yes _No

Do you have difficulty falling asleep at night? _Yes _No

Do you experience heartburn or wake up with a bitter taste in your mouth? _Yes _No

Are your menses painful? _Yes _No

Do you feel your menstrual cramps in the external genital area? _Yes _No

Is your menstrual blood thick and dark, or purplish in color? _Yes _No

Is your tongue dark or purplish in color? _Yes _No

DIAGNOSIS

HEART DEFICIENCY (Ht-) (*often associated with heat*)

Do you wake up early in the morning and have trouble getting back to sleep? _Yes _No

Do you have heart palpitations, especially when anxious? _Yes _No

Do you have nightmares? _Yes _No

Do you seem low in spirit or lacking in vitality? _Yes _No

Are you prone to agitation or extreme restlessness? _Yes _No

Do you fidget? _Yes _No

Is the tip of your tongue red? _Yes _No

Is there a crack in the center of your tongue that extends to the tip? _Yes _No

Do you sweat excessively, especially on your chest? _Yes _No

DIAGNOSIS

EXCESS HEAT (^H)

Is your pulse rate rapid? _Yes _No

Is your mouth and throat usually dry? _Yes _No

Are you thirsty for cold drinks most of the time? _Yes _No

Do you often feel warmer than those around you? _Yes _No

Do you wake up sweating or have hot flashes? _Yes _No

Do you break out with red acne (especially premenstrually)? _Yes _No

Do you have a short menstrual cycle? _Yes _No

Do you have vaginal irritation or rashes? _Yes _No

DIAGNOSIS

DAMPNESS (D)

Do you feel tired and sluggish after a meal? _Yes _No

Do you have fibrocystic breasts? _Yes _No

Do you have cystic or pustular acne? _Yes _No

Do you have urgent, bright, or foul-smelling stools? _Yes _No

Does your menstrual blood contain stringy tissue or mucus? _Yes _No

Are you prone to yeast infections and vaginal itching? _Yes _No

Do your joints ache, especially with movement? _Yes _No

Are you overweight? _Yes _No

Do you have a wet, slimy tongue? _Yes _No

DIAGNOSIS

DAMP HEAT (DH)

Do you have signs of heat and/or dampness as indicated above? _Yes _No

Do you have foul-smelling, yellow, or greenish vaginal discharge? _Yes _No

Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phase? _Yes _No

DIAGNOSIS

COLD UTERUS (CW)

Do you fit the Kidney Yang deficiency (Ki Yan-) category? _Yes _No

Do you fall into the Blood stasis pattern? _Yes _No

Does your lower abdomen feel cooler to the touch than the rest of your trunk? _Yes _No