Welcome to the YWBD clinic!

We would like to learn a little bit more about you. Please fill out this form as best as you can. The more we know, the better we can help you! All of the information on this sheet will be kept confidential.

Name: Date of Birth:

Best Number to Call: Is it ok to leave messages at this number?(Circle one) ☐ Yes ☐ No

What brings you to the clinic today?

_____

Approximately, when did you have your very first period? Month and year _____ Age _____

Do you have about one period a month? (Circle one) ☐ Yes ☐ No

If no, how often do you have a period? (eg every 14 days or every 45days)_____

Or, are they irregular? _____

Are you taking any medications to control your period (like hormones, lysteda)? (Circle one) ☐ Yes ☐ No If yes, which medications? _____

Are you taking any other medications including supplements? (Circle one) ☐ Yes ☐ No If yes, which medications? _____

When was your most recent period? (Date of Day 1 of bleeding) _____

How many days do your periods last? _____

Are your periods painful? ☐ Yes ☐ No

Do your periods limit your activities? ☐ Rarely ☐ Sometimes ☐ Usually

Which of the following do you use (ok to circle more than one)? ☐ Panty liners ☐ Pads ☐ Tampons

Who do you talk to about your period? _____

Do you see a doctor regularly? ☐ Yes ☐ No

If yes, please provide name (s): _____

Do you have any medical illnesses? ☐ Yes ☐ No

If yes, list them: _____

Is there anything else we should know about you? Any other questions that you want to ask?

_____

_____