Marcia D. Connelly, LAc, Dipl.OM
Live Oak Acupuncture & Healing Arts
245 at The Circle Family Center,
Sea Ridge Road, Aptos, CA
831.818.7051

**Download this form to your computer. Fill it out completely and email to Marcia: mcherbgal@gmail.com**

# Women's Health Assessment

name: date:

***Place a "C" *in front of* all that applies to your CURRENT state of health**
***Place a "P" *in front of* all that applies to your PAST health history**

____Irregular menses ____Heavy menses ____Scanty menses ____Spotting ____Fibroids ____Ovarian cysts ____Cramping
____High Libido ____Low Libido____Pain w/Sex____Loose stools ____Constipation ____Acne ____PMS ____Mood swings
____Low appetite ____Frequent breast tenderness ____Breast swelling ____Bloating ____Vaginal dryness ____Migraines
____Frequent headaches ____Poor vision ____Vision changes ____Dry eyes ____Low back pain ___Frequent thirst/hunger
____Water retention/edema ____Irritability ____Depression ____Anxiety____Nausea/Vomiting____Ear ringing ___Seizures
____Sleep disturbances/insomnia ____Frequent nightmares ____Hot flashes ___Night sweats ____Day sweats____
____Frequent yeast infections ___Hair thinning ____Dry/Brittle hair ____Frequent urination ____Frequent/chronic UTI
____Scanty urination ____Blood in urine ____Dizziness ____Anemia ___Cold hands/feet ___Crave Ice/Cold beverages
____Dry Throat____Dry Skin____Thyroid disorder ___Low energy ___Hyper-energetic ____Energy crashes ___Bitter taste
____Shortness of breath ____Chest pain/tightness ____Palpitations ____Gall stones ___Crave sweet/salty ____Memory loss
____Digestive complaints ___Difficulty losing/gaining weight ____Unclear/foggy thinking ____Shaking/trembling

**GYNECOLOGICAL HEALTH PROFILE:** Perimenopausal or Postmenopausal? **Yes** ☐ **No** ☐

___# of days in your cycle (**cycle length= first day of menstrual flow to first day of next menstrual flow**)
_____# of days you bleed
_____ LMP (**1st day of last menstrual period**)

What is the color/consistency of your menstrual blood (Please check all that apply):

| **Pale Red** | **Bright Red** | **Dark/Purple** | **Thin/Watery** | **Thick /Sticky** | **Dark Clots** | **Large Clots** | **Small Clots** |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**Pregnancy:** Please enter: _____**# of Miscarriages** _____**#of Abortions**_____**# of Live Births**

Is there any history of sexually transmitted infection(s)? **Y/N** If so, please list: Yes ☐ No ☐

Were there any complications related to miscarriage, abortion or birth? **Y/N** If so, please explain briefly:

**Please briefly list ANY MAJOR MEDICAL EVENTS: surgeries, illnesses and the approximate Age/Date at which they occurred, if need be, continue the list on the backside of this form:**

**Please briefly describe your vision of optimal health:**

*Are you interested in taking herbs/supplements? **Y/N**
*Would you like to receive mail/email regarding lectures, classes, coupons, gift certificates, and newsletters from our clinic? **Y/N** **Yes** ☐ **No** ☐