

Name \_\_\_\_\_  
Date \_\_\_\_\_  
Date of LMP \_\_\_\_\_

Cycle Length \_\_\_\_\_  
# of days of spotting prior to period \_\_\_\_\_  
# of days of spotting after period \_\_\_\_\_

**CYCLE**

Day 1	<input type="checkbox"/> Spotting	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Scanty	<input type="checkbox"/> Brown	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Crimson	<input type="checkbox"/> Clots
Day 2	<input type="checkbox"/> Spotting	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Scanty	<input type="checkbox"/> Brown	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Crimson	<input type="checkbox"/> Clots
Day 3	<input type="checkbox"/> Spotting	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Scanty	<input type="checkbox"/> Brown	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Crimson	<input type="checkbox"/> Clots
Day 4	<input type="checkbox"/> Spotting	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Scanty	<input type="checkbox"/> Brown	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Crimson	<input type="checkbox"/> Clots
Day 5	<input type="checkbox"/> Spotting	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Scanty	<input type="checkbox"/> Brown	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Crimson	<input type="checkbox"/> Clots
Day 6-7	<input type="checkbox"/> Spotting	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Scanty	<input type="checkbox"/> Brown	<input type="checkbox"/> Red	<input type="checkbox"/> Purple	<input type="checkbox"/> Crimson	<input type="checkbox"/> Clots

**PMS**

**CRAMPING**

**MEDICINES TAKEN**

<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Irritability	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Uterus	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Aleve	<input type="checkbox"/> Other	How Many per Day? _____
<input type="checkbox"/> Ovulation Pain	<input type="checkbox"/> Tender / Weepy	<input type="checkbox"/> Loose Stool	<input type="checkbox"/> Groin	<input type="checkbox"/> Motrin	<input type="checkbox"/> Midol		
<input type="checkbox"/> Tender Breasts	<input type="checkbox"/> Fatigue		<input type="checkbox"/> Low Back	<input type="checkbox"/> Tylenol	<input type="checkbox"/> Ibuprofen		Which day of your Cycle _____

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