NORTHERN MICHIGAN UNIVERSITY
ATHLETIC TRAINING
Menstrual History Questionnaire

To help complete your physical examination and medical history, please complete the following information as accurately as possible.

Some of these questions deal with personal information. Please be assured that your questions will remain confidential.

1. Date of last pap smear: ________________________________
2. Approximate age of first menstrual period: ________________
3. When was your last period? (Indicate month and year) ________________________________
4. How often have you had menstrual periods in the last year?
   ___ Once every 20 days or less   ___ Every 21-27 days
   ___ Every 28-35 days   ___ Every 36-50 days
   ___ Every 3-4 months   ___ Very irregular; sometimes monthly, sometimes skip several months
   ___ Other (please specify) _______________________________________________________
5. Periods usually last ___________ days.
6. Number of periods in last 12 months ____________
7. What is the longest you have gone without having a menstrual period? ____________
8. My menstrual flow is usually:   ___ light   ___ moderate   ___ heavy
9. Do you have bleeding between periods? ___ yes   ___ no
10. Do pain and cramping accompany your menstrual cycle? ___ not at all   ___ slightly   ___ a great deal
11. If yes, do you (check all that apply)
    ___ Take pain medication
    ___ Lose time from school, job, or other function
    ___ Function less efficiently at school, job, or home
    ___ Reduce you level of physical exercise/training
    ___ Miss practice/workout days
    ___ Continue workouts but decrease training level
    ___ Continue daily life without little change
12. Do you think vigorous exercise/training affects your menstrual periods? ___ yes  ___ no
   If yes, please explain these changes ____________________________________________________________

13. Have you ever seen a medical practitioner about problems associated with your period? ___ yes  ___ no
   If yes, what did they tell you?________________________________________________________________

14. Do you take any type of estrogens (ie oral contraceptives? ___ yes  ___ no
   If yes, explain ____________________________________________________________________________

15. Do you consider yourself ___ Underweight
    ___ Slightly underweight
    ___ Just right
    ___ Slightly overweight
    ___ Overweight

16. Have you ever had a significant weight loss or gain? ___ yes  ___ no
   If yes, explain ____________________________________________________________________________

17. In the past year has your weight:
    ___ Basically stayed the same (varied 1 to 5 lbs.)
    ___ Increased
    ___ Decreased

18. Do you have a history of stress fractures? ___ yes  ___ no

19. Do you currently have any problems that you feel influence your diet? _______________________________

20. Is your diet well balanced? ___ yes  ___ no

21. Do you take vitamins? ___ yes  ___ no

22. Do you take calcium tablets? ___ yes  ___ no
   If yes, brand and dosage ________________________________________________________________

23. Usual serving per day
   Meat/fish _____ Milk (glasses per day) _____
   Fruit _____ Coffee/tea (cups per day) _____
   Vegetable _____ Juice/fruit drink (cups per day) _____
   Eggs _____ soft drinks (per day) _____
   Bread _____ Water (glasses per day) _____
   Potatoes _____ Gatorade or other sport drinks _____
   Grain/cereal _____ Cheese _____

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