

Name: \_\_\_\_\_

Sport: \_\_\_\_\_

Date: \_\_\_\_\_

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                           | _____ |