MCAC MENSTRUAL CYCLE AFTER CONCUSSION

Name _____ Date _____ Age _____

PERIODS

Menarche

Age when your periods started _____ School grade _____

Current

Date: first day of last period _____ Cycles are regular Yes _____ No _____

Your Cycle

Monthly periods before concussion: 1 ____ 2 ____ More than 2 _____ Sometimes no period _____

Monthly periods after concussion: 1 ____ 2 ____ More than 2 _____ Sometimes no period _____

Lack of Periods

Missed period this month? Yes ____ No ____ Number of months without a period _____

Hormones

Are you taking any female hormones (estrogen, progesterone, oral contraceptives)?

Yes _____ No _____ If yes, describe: _____

CHANGES

Flow

After your concussion, has your period flow changed? Yes _____ No _____

Heavier flow (bleeding more) ___ Lighter flow (bleeding less) ____ About the same _____

Duration

How long is your period now compared to before your concussion?

Longer (more days) ___ Shorter (fewer days) ____ About the same ____ Stopped completely ____

SYMPTOMS

Worse with your periods

Enter a number from 1-5 for each symptom that's worse with your period. 1 = low, 5 = high

_____ Headache	_____ Nausea	_____ Fatigue
_____ Vertigo	_____ Vomiting	_____ Sadness
_____ Dizziness	_____ Noise sensitivity	_____ Depression
_____ Balance	_____ Light sensitivity	_____ Suicidal thoughts
_____ Vision issues	_____ Concentration	_____ Other _____
_____ Neck pain	_____ Feeling foggy	_____

SYMPTOMS

Symptoms you have during your period

Symptom	Less				More	Worse than before concussion or last visit?
Headache	1	2	3	4	5	Yes ____ No ____ N/A ____
PMS	1	2	3	4	5	Yes ____ No ____ N/A ____
Pain (overall)	1	2	3	4	5	Yes ____ No ____ N/A ____
Neck issues	1	2	3	4	5	Yes ____ No ____ N/A ____
Vertigo	1	2	3	4	5	Yes ____ No ____ N/A ____
Dizziness	1	2	3	4	5	Yes ____ No ____ N/A ____
Balance	1	2	3	4	5	Yes ____ No ____ N/A ____
Vision issues	1	2	3	4	5	Yes ____ No ____ N/A ____
Nausea	1	2	3	4	5	Yes ____ No ____ N/A ____
Vomiting	1	2	3	4	5	Yes ____ No ____ N/A ____
Noise sensitivity	1	2	3	4	5	Yes ____ No ____ N/A ____
Light sensitivity	1	2	3	4	5	Yes ____ No ____ N/A ____
Fatigue	1	2	3	4	5	Yes ____ No ____ N/A ____
Concentration	1	2	3	4	5	Yes ____ No ____ N/A ____
Feeling foggy	1	2	3	4	5	Yes ____ No ____ N/A ____
Sadness	1	2	3	4	5	Yes ____ No ____ N/A ____
Depression	1	2	3	4	5	Yes ____ No ____ N/A ____
Suicidal thoughts	1	2	3	4	5	Yes ____ No ____ N/A ____
Seizures	1	2	3	4	5	Yes ____ No ____ N/A ____

COMMENTS

_____

_____

_____

_____

_____

_____

_____

_____

_____