

Patient \_\_\_\_\_ DOB: \_\_\_\_\_

Year \_\_\_\_\_

# MENSTRUAL RECORD CHART

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	No. of days from start of period to beginning of next	Breast Exam Done (✓)			
Jan.																																				
Feb.																																				
Mar.																																				
Apr.																																				
May																																				
Jun.																																				
Jul.																																				
Aug.																																				
Sep.																																				
Oct.																																				
Nov.																																				
Dec.																																				

**TYPE OF FLOW**

- Normal  X
- Exceptionally light  O
- Exceptionally heavy  ■
- Spotting  S

*Don't forget to have this chart with you when you call or visit your doctor.*

Dr. \_\_\_\_\_