Menstrual Record Chart

Name _____

Address _____

Phone (_____) _____ Year _____

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 period	Breast exam done (✓)
Jan																																	
Feb																																	
Mar																																	
Apr																																	
May																																	
Jun																																	

TYPE OF FLOW

[X] Normal [O] Exceptionally light [ ] Exceptionally heavy [S] Spotting

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 period	Breast exam done (✓)
Jul																																	
Aug																																	
Sep																																	
Oct																																	
Nov																																	
Dec																																	

TYPE OF FLOW

[X] Normal [O] Exceptionally light [ ] Exceptionally heavy [S] Spotting

Don't forget to have this chart with you when you call or visit your health care professional.

ORTHO-McNEIL PHARMACEUTICAL, INC.
Raritan, New Jersey 08869-0602

Name of Health Care Professional

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