

**DoD Medical Examination Review Board
8034 Edgerton Drive, Suite 132
USAF Academy, Colorado 80840-2200**

GYN QUESTIONNAIRE

NAME: _____ SOCIAL SECURITY NUMBER: _____ - _____ - _____

Please answer ALL of the following questions regarding your menstrual cycle and return this form to DoDMERB at the above address. If more space is needed, please use back of form and identify each issue by question number.

PRIVACY ACT STATEMENT

AUTHORITY: Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397

PRINCIPAL PURPOSE: To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corp (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

ROUTINE USES: This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applicants to their Academies.

DISCLOSURE: Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1) Your age at onset of menstrual cycle _____

2) Provide begin/end dates of your last 3 menstrual cycles, regularity, and the type of flow.

Begin Date	End Date	Regular or Irregular	Type of Flow (heavy/moderate/light/spotting)

3) Have you been examined by a medical provider (GYN, Family Practitioner, Internal Medicine, etc.) for any female and/or menstrual related conditions? Yes No

If yes, what condition(s) have you been examined and/or treated for? _____

4) Describe the treatment and include date(s) {Example: Medication(s)/Procedure(s)}: _____

5) Does cramping or painful menstrual cycles exist? Yes No

If yes, does it interfere with routine activities for more than a few hours? Yes No

If yes, describe limitations: _____

What medication(s) is/are taken for pain relief? If none, please indicate. _____

6) Do you currently take birth control medication? Yes No

If yes, state the medication, dose and reason for use: _____

7) Certification: By signing below, I hereby certify that the above information is true and accurate to the best of my knowledge.

Applicant's Signature

Date