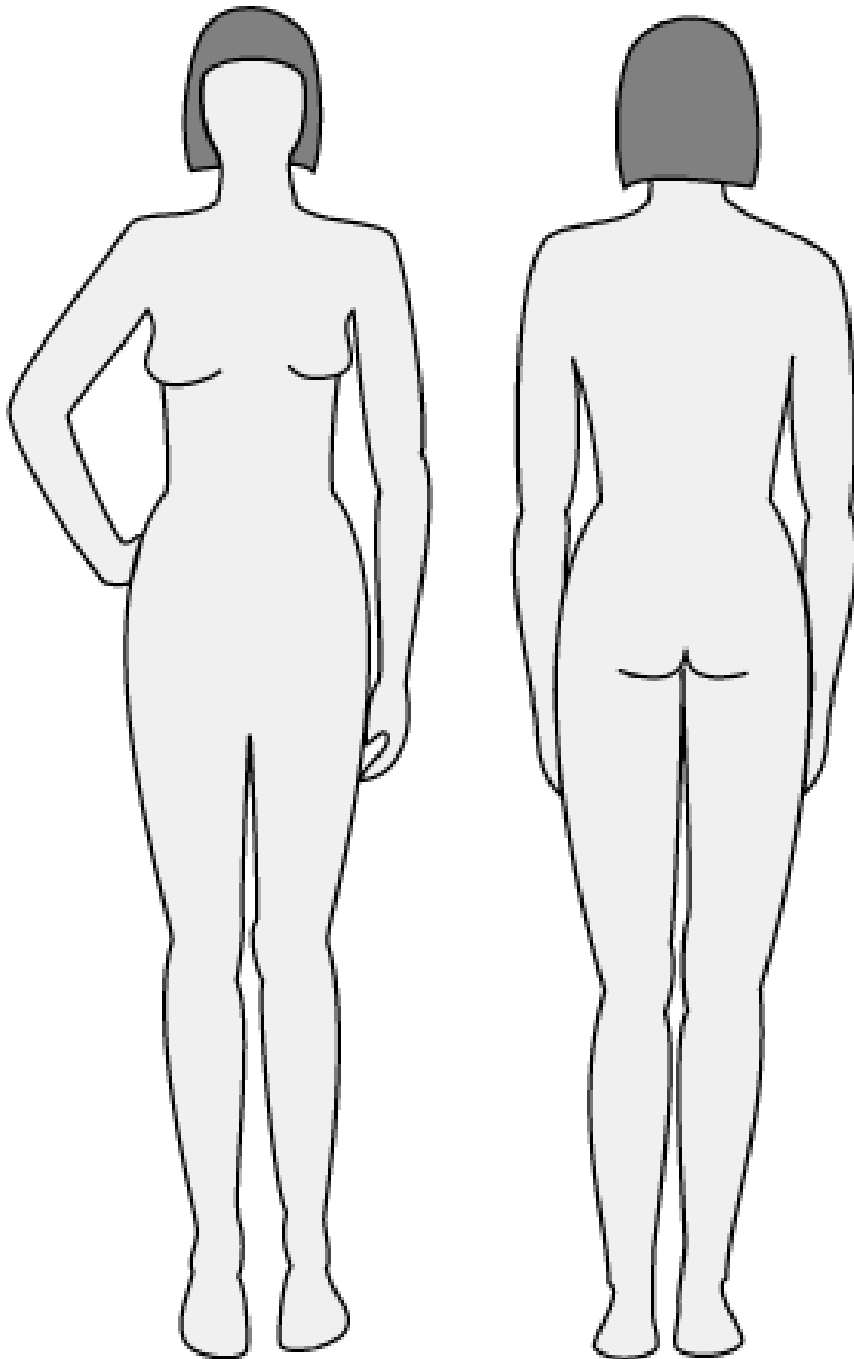


Personal Pain Profile

Dull aching and cramping occurs during periods for many women and teens. However, menstruation that is so unbearable it makes you unable to go about your normal routine is not typical. Pain is your body's way of signaling that something is wrong. One way to communicate with your doctor is by being as specific as you can about the location and the degree of pain you're experiencing.



Instructions for pain mapping:

- Mark a **"P"** over all of the areas in which you experience **pain during your period.**
- Mark an **"X"** over the areas in which you experience **pain during any other time of the month.**
- Mark a **"C"** over areas where you experience **pain constantly.**



For more resources and information on endometriosis, visit us on the web - www.endofound.org

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Personal Pain Profile: Daily Symptom Tracker



Instructions: Label Day 1 on the first day of your period, then write the day and date below the number. Check off or circle symptoms you are experiencing on that day, and if medication is required for symptoms. It is also helpful to your doctor if you can describe the location and severity of your pain, as well as other symptoms you may be experiencing. Remember to share this information with your physician!

Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____	Day # _____ Date _____ <input type="checkbox"/> Pain / Bloating <input type="checkbox"/> Heavy Bleeding <input type="checkbox"/> Exhaustion <input type="checkbox"/> Digestive Distress <input type="checkbox"/> Medication Other _____
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