MENSTRUAL CRAMPS
(example – Dysmenorrhea)

Subjective Data:
Allergies: ________________________________

Chief complaint: ___________________________________________________________________________________

Onset: __________________
  □ New Onset  □ Chronic  □ Recurrence

History:
Last normal menstrual period: ________________

Associated Symptoms:

Change in voiding: □ Yes  □ No  If “Yes” describe: _____________________________________________________________

Lumbosacral back pain or mid-abdominal pain: □ Yes  □ No  If “Yes” describe: ___________________________________________________________

Excessive bleeding or discharge: □ Yes  □ No  If “Yes” describe: ________________________________________________

Radiation of pain: □ Yes  □ No  If “Yes” describe: ________________________________________________________________

Pain scale: (0 – 10) ________

Nausea  □  Vomiting  □  Headache  □  Chills  □  Tiredness  □  Nervousness

Objective Data: (clinically indicated VS)
BP _______ Pulse _______ Resp. _______ Temp. _______ Wt. _______ O₂ sat. _______ FSBS: __________

Respiration:
  □ Even  □ Uneven  □ Labored  □ Unlabored  □ Shallow

Heart sounds:
  □ Regular  □ Irregular  □ Alert

Abdomen:
  □ Soft  □ Slightly firm  □ Rigid

Posture:
  □ Able to stand erect  □ Unable to stand erect  □ Able to bend legs while lying  □ Unable to bend legs while lying

Appearance:
  □ No distress  □ Mild distress  □ Moderate distress  □ Severe distress

REFER TO HEALTH CARE PROVIDER IF:
If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.

□ No relief from analgesics  □ Pain not related to menstrual cramps  □ Excessive bleeding or clots  □ Cramps associated with severe pain  □ Temp > 101

Health Care Provider: ___________________ Time Notified: _______ Orders Received for Treatment: □ Yes □ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

□ Check in assessment only for health care providers visit.
□ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
□ Warm, moist heat to abdomen
□ Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days PRN  OR
□ Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days PRN
□ Education/Intervention: Instructed to increase exercise (exercise increases neuro-physiologic basis for relief), avoid restrictive clothing, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: _______________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Health Care Provider Signature/Credentials: ________________________________ Date: ________ Time: ________

RN/LPN Signature/credentials: ________________________________ Date: ________ Time: ________

Inmate Name __________________________ (Last, First)  DOC #________