

**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)

<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headache	<input type="checkbox"/> Chills	<input type="checkbox"/> Tiredness	<input type="checkbox"/> Nervousness
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**Objective Data:** (clinically indicated VS)

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp. \_\_\_\_\_ Wt. \_\_\_\_\_

<b>Respiration:</b>	<input type="checkbox"/> Even	<input type="checkbox"/> Uneven	<input type="checkbox"/> Labored	<input type="checkbox"/> Unlabored	<input type="checkbox"/> Shallow
<b>Heart sounds:</b>	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular	<input type="checkbox"/> Alert		
<b>Abdomen:</b>	<input type="checkbox"/> Soft	<input type="checkbox"/> Slightly firm	<input type="checkbox"/> Rigid		
<b>Posture:</b>	<input type="checkbox"/> Able to stand erect	<input type="checkbox"/> Unable to stand erect	<input type="checkbox"/> Able to bend legs while lying	<input type="checkbox"/> Unable to bend legs while lying	
<b>Appearance:</b>	<input type="checkbox"/> No distress	<input type="checkbox"/> Mild distress	<input type="checkbox"/> Moderate distress	<input type="checkbox"/> Severe distress	

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

**Refer to Medical Provider If:**

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

**Medical Provider Notified: Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Orders Received for Treatment:**  Yes  No

**Assessment:**

- Alterations in comfort related to menstruation

**Plan: Nursing Intervention Routine:** (check all that apply)

- Check in assessment only for medical providers visit.
- Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.
- Warm, moist heat to abdomen
- Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4days
- OR**
- Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 days
- 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. Offender verbalizes understanding of instructions.

**Progress Note:** \_\_\_\_\_

**Medical Provider Signature/Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**QHCP Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Offender Name  
(Last, First)

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