

Travelling Cycles Notepad

Date	Menses	SBE	Spotting	Wgt	Symptoms	Xfr
	<input type="checkbox"/> Spotting <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Lying <input type="checkbox"/> Down	<input type="checkbox"/> Yes		<input type="checkbox"/> Acne <input type="checkbox"/> Anxiety <input type="checkbox"/> Backache <input type="checkbox"/> Bloating <input type="checkbox"/> Breast Swelling <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Cramps <input type="checkbox"/> Constipation <input type="checkbox"/> Decr. Concentration <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fatigue <input type="checkbox"/> Food Cravings <input type="checkbox"/> Headached <input type="checkbox"/> Irritability <input type="checkbox"/> Joint Pain <input type="checkbox"/> Moody <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Ovarian Pain <input type="checkbox"/> Sadness <input type="checkbox"/> Tension <input type="checkbox"/> Water Retention <input type="checkbox"/> Weight Gain	
Notes:						
	<input type="checkbox"/> Spotting <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Lying <input type="checkbox"/> Down	<input type="checkbox"/> Yes		<input type="checkbox"/> Acne <input type="checkbox"/> Anxiety <input type="checkbox"/> Backache <input type="checkbox"/> Bloating <input type="checkbox"/> Breast Swelling <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Cramps <input type="checkbox"/> Constipation <input type="checkbox"/> Decr. Concentration <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fatigue <input type="checkbox"/> Food Cravings <input type="checkbox"/> Headached <input type="checkbox"/> Irritability <input type="checkbox"/> Joint Pain <input type="checkbox"/> Moody <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Ovarian Pain <input type="checkbox"/> Sadness <input type="checkbox"/> Tension <input type="checkbox"/> Water Retention <input type="checkbox"/> Weight Gain	
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Notes:						

Code	Action
Date	Enter the date for which you recording menstrual cycle or related activity
Menses	If you had your period on this date, check off the flow level.
SBE	If you performed a self breast exam, check off the position when performed.
Spotting	If spotting occurred on this day – not during your period – check Yes.
Wgt	If you've weighed in on this date, enter your weight in this column.
Symptoms	If a symptom occurred, indicate its severity level: MI = Mild, MO = Moderate, SEV = severe
Xfr	Check off as you transfer your information into MyMonthlyCycles.com