Female Health History Questionnaire

(To be completed by patient)

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Weight: _____ Height: _____

Chief Complaint(s):

_____

_____

_____

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

□ Antacids, Zantac, Pepcid AC, Rolaids, etc.
□ Chemotherapy

□ Laxatives
□ Ulcer medications
□ Antibiotic/Antifungal

□ Anti-diabetic/Insulin

□ Oral contraceptives

□ Relaxants/Sleeping pills
□ Thyroid
□ Radiation
□ Antidepressants

□ Aspirin/Acetaminophen
□ Cortisone/Anti-Inflammatory
□ Heart medications
□ High blood pressure medicine
□ Statins/Cholesterol lowering medications

□ Hormones – If so, what? _____ When? _____ Dosage? _____

Please list names of any medications you are currently taking:

_____

_____

_____

_____

_____

Are you allergic to any drugs that you know of? (if so please list names):

_____

_____

_____

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking:

_____
_____
_____
_____
_____

Surgeries, Accidents, Trauma's – Please list any surgeries, accidents, or trauma's you have had. Please be sure to include dates as well.

_____
_____
_____
_____
_____

Lifestyle

Dietary Habits: Describe the foods you normally eat:

BREAKFAST: _____
_____
LUNCH: _____
_____
DINNER: _____
_____
SNACKS: _____
_____

Do you consume the following?			**If so, how much?**
1. Soda or carbonated beverages?	YES	NO	_____
2. White flour products?	YES	NO	_____
3. Fried foods?	YES	NO	_____
4. Coffee?	YES	NO	_____
5. Fast foods regularly?	YES	NO	_____
6. Sweets and/or refined carbohydrates?	YES	NO	_____
7. Alcoholic beverages?	YES	NO	_____
8. Any tobacco products?	YES	NO	_____

Are you a vegetarian? YES NO

Are you currently involved in an exercise program? YES NO How often? _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
How do you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

Female Anatomy / Reproductive Health *(to be completed by all women)*

Age at onset of first period: _____ Approximate date of onset: _____

What are you using for contraception at the moment? _____

Have you ever used ***oral, injected, patch, or ring*** hormone contraceptives, or used *Emergency Contraception ("the day after" pill)?* YES NO
From _____to_____
Did you suffer from any side effects? YES NO Explain: _____

Are you currently or have you ever used and IUD? YES NO
When? _____ For how long? _____

While under the use of any and all birth control methods, did you experience the following? Y*east, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.* ***(Please circle and use extra space provided if explanation is needed)***
_____
_____
_____

Are you currently, or have you ever used fertility treatment? YES NO
If yes, please explain. _____
_____

Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc.? YES NO

If yes, what hormone(s), dosage and for how long? **Please be specific with dates of use.**
_____
_____

Do you have any history of abnormal Pap Tests? YES NO
If yes, please explain: _____
Please describe any treatment and/or medication for this: _____

Do you have any history of vaginal infections? YES NO
If yes, please describe: _____
Please describe any treatment and/or medication for this: _____

Do you have any history of the following conditions? (*Please circle appropriate answer)*
Ovarian Cysts, Fibrocystic Breasts, Polycystic Ovarian Syndrome (PCOS), Uterine Fibroids, Endometriosis, Lichen Sclerosis, Vulvodynia

Pregnancy History *(to be completed by all women, it applicable)*

Have you been pregnant before? YES NO
Please list the age(s) of your children:
_____

Please explain important details/complications below:

Number of pregnancies: _____ _____
Number of live births: _____ _____
Number of miscarriages: _____ _____
How many weeks gestation at the time of miscarry? _____ Weeks
Number of premature births: _____ _____
Number of cesarean births: _____ _____
Number of stillbirths: _____ _____
Number of ectopic pregnancies: _____ _____

All menopausal women should now skip to the bottom section of page 5 labeled "menopausal women" and continue on with the remainder of this questionnaire.

Cycling History *(to be completed by all women who have not reached menopause)*

What was the first date of your last menstrual period (LMP)? _____

Have you ever had tubal ligation surgery? YES NO
If so, please list the date and specific details: _____
_____

Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle? *(Please circle appropriate answer)*
<20 days 20-30 days 30-40 days 40-50 days >50 days

What is the length of days your menstruation typically lasts? _____

Do you consider your cycle to be regular? YES NO Not Always
Details: _____

What is your typical menstrual flow like? Light Medium Heavy
Details: _____

How many <u>pads</u> and/or <u>tampons</u> *(circle)* do you use on heavy days? _____
During menstruation, do you pass blood clots? YES NO How often? _____

How would you describe your cramping? None Mild Moderate Severe
At what point in your cycle? _____

Cycling History, Cont'd *(to be completed by all women who have not reached menopause)*

Have you noticed any recent changes to your cycle? If yes, explain: _____

Do you experience any unusual or excessive vaginal discharge throughout the month?
YES NO When? _____

Do you ever experience itching or odor in the vaginal area? YES NO
When? _____

Do you experience any breast tenderness? None Mild Moderate Severe
If yes, at what point in your cycle? _____

Do you have nipple discharge at any point in your cycle? YES NO
If yes, at what point in your cycle? _____ Color? _____

All cycling women should now skip to the bottom section of page 6 labeled "sleep" and continue on with the remainder of this questionnaire.

Menopausal Women

What age were you at the onset of menopause? _____ Year of onset? _____
Date of your last menstrual period? _____

Please describe any recent changes and/or symptoms associated with your cycle prior to menopause:_____
_____
_____
_____

Please list any and all GYN surgeries: What was the reason for each surgery?

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Please give an in depth explanation of how you perceive your experience transitioning into menopause: *(for example, please list symptoms, emotional changes, thoughts, stressors, etc.)*
_____
_____
_____

Are you currently, or have you ever used conventional hormone replacement (HRT)? _____
If yes, please list the name of the prescription: _____
What is/was the dosage? _____ For how long? _____

Menopausal Women Continued…

Are you currently, or have you ever used bio-identical hormone creams/gels/sublingual, troche, oral? YES NO
If yes, please list the name(s) of each product: _____
What is/was the dosage? _____ For how long? _____

Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? YES NO
If yes, please list the name(s) of each product: _____
What is/was the dosage? _____ For how long? _____

Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? YES NO
If yes, what? _____
Treatment: _____

Below please describe your cycle history.

Would you have described your menstruation as: Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling would you describe your cycle as regular? YES NO
If no, please give explanation: _____
_____

In the past, if you have ever received any type of "treatment" for any cycle issues would you please explain: _____
_____
_____

Sleep

How well do you sleep?
□Well □ Trouble falling asleep □ Trouble staying asleep □ Insomnia

What is the average number of hours you most often sleep each night? _____
Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO
If yes, how often? _____

Do you keep your room completely dark at night? YES NO

Signs & Symptoms *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simply leave it blank.***

Section 1:

Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestion?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/Nausea? (circle)	1	2	3

Section 2:

Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
Persistent Gas?	1	2	3
Digestive problems?	1	2	3

Section 3:

Low blood sugar / hypoglycemia?	1	2	3
Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine/stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

Section 4:

Low mood/depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

Signs & Symptoms, Cont'd *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simply leave it blank.***

Section 5:

Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships? (circle)	1	2	3
Decreased initiative/motivation/drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness/crying? (circle)	1	2	3

Section 7:

Decrease in strength/stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decreased lean muscle mass?	1	2	3
Muscle soreness/weakness? (circle)	1	2	3
Body/joint aches? (circle)	1	2	3
Increased fat on hips/breasts/thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/Migraines? (circle)	1	2	3
Muscle pain/Joint aches/Backache? (circle)	1	2	3

Section 9:

Head hair loss/body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Signs & Symptoms, Cont'd *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simply leave it blank.***

Section 10:

Infertility?	1	2	3
Lowered/Heightened libido? (circle)	1	2	3
Hot flashes?	1	2	3
Night sweats?	1	2	3
Palpitations?	1	2	3
Breast tenderness?	1	2	3
Breast cysts?	1	2	3
Vaginal infections/Yeast infections? (circle)	1	2	3
Urinary frequency/Incontinence/Infections? (circle)	1	2	3
Changes to labia/clitoral tissue (Atrophy, thinning, discoloration, itching, burning)? (circle)	1	2	3
Vaginal changes (dryness, tearing, decreasing size)? (circle)	1	2	3
Bone loss/osteoporosis?	1	2	3
Endometriosis?	1	2	3
Pelvic inflammatory disease?	1	2	3
Cystitis?	1	2	3
Ovarian cysts?	1	2	3
Fibroids?	1	2	3