

Female Health History Questionnaire

Name _____ Age: _____ Today's date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

What is the reason for this visit?

List any medications you are currently taking:

List any natural supplements, herbs, or remedies you are currently taking:

Please list athletic performance supplements you have or are currently taking: _____

List any known drug allergies: _____

Significant non-GYN health issues (diabetes, surgical procedures, hospitalizations, etc.):

List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.). When and why?

Date of last pelvic/gynecological exam: _____ Last Pap Test: _____ Last mammogram: _____

Last thermography? _____ Unusual results? _____

Are you currently under another physician's care? _____

Do you drink alcohol? Yes No How much and how often? _____

Do you smoke? Yes No How much/often? _____

How often do you exercise? never rarely sometimes regularly competitively

Please mark the following symptoms as they apply to you. Specify the time within your cycle and the severity of your symptoms. Also, provide additional information and details where appropriate.

| Symptom | Just w/ period | Ongoing | Mild | - | Moderate | - | Severe | More Information |
|----------------------------------|---------------------------|----------------|-------------|----------|-----------------|----------|---------------|-------------------------|
| Mood swings | | | | | | | | |
| Anxiety/Nervousness | | | | | | | | |
| Overly Reactive/Short fuse | | | | | | | | |
| Irritability | | | | | | | | |
| Depression | | | | | | | | |
| Lowered self-esteem/self-image | | | | | | | | |
| Caretake others before yourself | | | | | | | | |
| Sadness | | | | | | | | |
| Crying | | | | | | | | |
| Foggy thinking | | | | | | | | |
| Memory difficulties | | | | | | | | |
| Fatigue | | | | | | | | |
| Constant hunger | | | | | | | | |
| Sweet cravings (carbs/chocolate) | | | | | | | | |
| Hypoglycemia | | | | | | | | |
| Hyperglycemia (diabetes) | | | | | | | | |
| Weight gain | | | | | | | | |
| Weight loss | | | | | | | | |
| Bloating | | | | | | | | |
| Water retention | | | | | | | | |
| Irritable Bowel | | | | | | | | |
| Constipation | | | | | | | | |
| Diarrhea | | | | | | | | |
| Nausea/vomiting | | | | | | | | |
| Headaches | | | | | | | | |
| Body/Joint Aches | | | | | | | | |
| Back Ache | | | | | | | | |
| Acne | | | | | | | | |
| Excessive facial hair | | | | | | | | |
| Dry eyes | | | | | | | | |
| Lowered Libido | | | | | | | | |
| Heightened Libido | | | | | | | | |
| Difficulty getting to sleep | | | | | | | | |
| Difficulty staying asleep | | | | | | | | |
| Hot flashes | | | | | | | | |
| Night sweats | | | | | | | | |
| Breast tenderness/swelling | | | | | | | | |
| Nipple discharge | | | | | | | | |
| Vaginal infections | | | | | | | | |
| Urinary frequency | | | | | | | | |
| Incontinence | | | | | | | | |
| Vaginal dryness | | | | | | | | |
| Painful intercourse | | | | | | | | |

Reproductive Health History (please fill in or circle the appropriate answer)

Age at onset of menarche (first period): _____ Approximate date of onset: _____

Are you currently using a method of birth control? Yes No

If yes, what method? _____

Are you, or have you ever used (please circle) oral, injected, patch, or ring hormone contraceptives? Yes No

When and for how long? _____

Have you ever used Emergency Contraception (aka "the day after pill")? Yes No Year: _____

Any unusual reactions? _____

Are you, or have you ever used an IUD? Yes No If yes, when and for how long? _____

What type of IUD did you use? copper hormone other _____

Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue depression, palpitations, etc.)

Have you used, or are you currently using, fertility intervention or treatment? Yes No

If yes, please explain. _____

Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No

If yes, please explain: _____

Please provide details of unusual circumstances or complications surrounding any pregnancies.

Have you been pregnant before? Yes No

Number of pregnancies? _____ Details/ Complications: _____

Number of live births: _____

Miscarriages: _____

Premature births: _____

Cesarean births: _____

Stillbirths: _____

Abortions: _____

Ectopic pregnancies _____

If you have had a miscarriage, at what stage of gestation were you? _____

Did you breastfeed? Yes No How long? _____
 Did you have any difficulties? Yes No Please explain. _____
 Have you ever had an abnormal Pap Test? Yes No Reason? _____
 Have you ever tested positive for a sexually transmitted disease? Yes No
 If yes, what? _____ Did you receive treatment? Yes No
 Have you a history of ovarian cysts? Yes No Uterine fibroids? Yes No
 Cervical Dysplasia? Yes No Endometriosis? Yes No

Please fill in the appropriate box based on your status as a cycling-aged or menopausal woman. If you have had a hysterectomy, please fill out the questions for menopausal women.

For Cycling-Aged Women (please fill in or circle the appropriate answer)

Date of your last menstrual period: _____
 Has there been any recent change to your cycle or to the symptoms associated with your cycle? Yes No
 If yes, please give details. _____

 How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)
 <20 _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
 How many days does menstruation typically last? _____
 Is your cycle regular? Yes No Not Always Details: _____
 Typical menstrual flow: Light Medium Heavy Details: _____
 How many pads or tampons (circle which) are used on heavy days? _____
 Do you pass clots? Yes No How often? _____
 Do you spot? Yes No At what point in your cycle? _____
 Do you experience cramping? None Mild Moderate Severe
 At what point in your cycle? _____
 Do you experience vaginal discharge? Yes No If yes, when? _____
 Do you experience yeast or itching with your cycle? Yes No If yes, when? _____
 Do you experience breast tenderness? None Mild Moderate Severe
 At what point in your cycle? _____ Change in breast size? Yes No
 Have you ever experienced nipple discharge? Yes No If yes, when? _____
 What color? _____

For Menopausal Women (please fill in or circle the appropriate answer)

Your age at the onset of menopause: _____ Year of onset: _____

Have you had a hysterectomy? complete (ovaries AND uterus) partial (ovaries OR uterus) none

Describe your experience transitioning into menopause (symptoms, strong emotions, thoughts, unusual stressors, etc.)

Have you used, or are you currently using, estrogen or hormone replacement therapy (HRT)? Yes No

If so, how many years? _____ What were you prescribed? _____

Have you used, or are you currently using, any bioidentical hormone creams/gels/sublingual? Yes No

If yes, what? _____

Have you utilized any alternative, complimentary, or natural remedies in your management of menopause? Yes No

If yes, what? _____

Please describe your cycle history.

How would you have described your menstruation?

Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling would you consider your cycle regular? Yes No

If no, explain. _____

Please describe any 'treatment' you ever received for cycle issues. _____

Sleep Habits

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

How long has this been happening? _____

Do night sweats wake you up? Yes No How long? _____

Do you wake up tired? Yes No How long? _____

How many hours do you sleep a night on average? _____ Do you wake up tired? Yes No

Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No

Do you get at least 30 minutes of outside daylight time, several days each week? Yes No