Female History Questionnaire

Name ____ Age: ______ Today's date: _____________

D.O.B.____________ Weight: ______ Height: ________ Occupation: ___________________________

What is the reason for your visit?

____

____

____

List any medications you are currently taking:

____

____

List any natural supplements or remedies you are currently taking:

____

____

* *

1. At what age did you begin menstruating (onset of menarche)? ___________
   a. Number of days of cycle: ___________
   b. How many days of bleeding: ________________
2. Have you ever been pregnant? Yes No How many times? ________
3. Do you have children? Yes No
   a. How many? ______ Ages __________________________
4. Have you had a miscarriage or ectopic pregnancy? Yes No What year(s) _____________
5. Check any contraceptive you have used: oral injected patch
   a. When & How Long? ____
   b. For what reason?

      ____

      ____
6. Do you have any discomfort, PMS, or other symptoms around the time of your period?

   ____
7. Bleeding problems:
   a. Heavy bleeding Yes No If Yes, how many days? _____________________________

      (Heavy bleeding is indicated if you saturate tampons or pads more than 4 times per day)
   b. Spotting Yes No If yes, how many days? ____________________________________
   c. Clotting Yes No
   d. Cramping Yes No If yes, when? ____
   e. Other ____

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Female History Questionnaire

Cont'd

8. List GYN procedures or surgeries: Ovaries, hysterectomy, breast, other—When and Why:
   ____
   ____
9. Significant health problems:____
   a. Illnesses ____
   b. Surgical procedures ____
   c. Hospitalizations ____
   d. Other ____
10. Do you drink more than 2 alcoholic beverages per day? _____________
11. Do you smoke? _____________ How much? ______________________________________

Place an "X" next to the symptoms that apply to you.

1. _____ Mood swings _____ Mild _____ Moderate _____ Severe
2. _____ Irritability _____ Mild _____ Moderate _____ Severe
3. _____ Anxiety; Nervous tension _____ Mild _____ Moderate _____ Severe
4. _____ Short fuse _____ Severe temper _____ Rage _____ Aggression
5. _____ Overly sensitive
6. _____ I take care of everyone else in my life before myself
7. _____ Depression _____ Mild _____ Moderate _____ Severe
8. _____ Lessened self-esteem or self-image
9. _____ Sadness _____ Crying
10. _____ Bloating _____ Water Retention
11. _____ Memory difficulties _____ Foggy thinking _____ Lack of concentration
12. _____ Sweet cravings, Carbohydrate cravings, chocolate cravings worse before menses
13. _____ Candida (yeast infections)
14. _____ Hypoglycemia
15. _____ Hyperglycemia (diabetes)
16. _____ Weight gain _____ Overweight
17. _____ Weight loss
18. _____ Fatigue
19. _____ Cold hands and feet
20. _____ Change in bowel habits _____ Constipation _____ Diarrhea
21. _____ Muscle / joint aches and pains
22. _____ Back ache

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Female History Questionnaire

Cont'd

23._____ Headaches / Migraines

a. When & How often? ____

b. Are they at specific times in your cycle? ___________________________

24._____ Nausea; vomiting

25._____ Acne _____ Oily skin

26._____ Excessive facial hair _____ Excessive body hair

27._____ Change in libido _____ Decreased _____ Increased

28._____ Difficulty sleeping _____ Insomnia

29._____ Hot flashes

30._____ Night sweats

31._____ Dry eyes

32._____ Vaginal dryness _____ Painful intercourse

33._____ Urinary frequency _____ Urinary incontinence

34. Any other related symptoms or concerns not covered above?

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