FEMALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

th Date: _____ Weight: _____ Height: _____ Occupation: _____

What is the reason for this visit?

_____

_____

List medications you are currently taking:

_____

_____

_____

Any known drug allergies? _____

List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

_____

_____

_____

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

_____

_____

_____

List significant non-GYN health issues (diabetes, surgeries, etc.):

_____

_____

_____

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 eat sugar/refined carbs? Yes No How much/how often? _____

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

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

)w often do you exercise? never rarely sometimes regularly competitively

SIGNS & SYMPTOMS	ONGOING	JUST W/ PERIOD	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						
Water Retention						
Bloating						
Irritable Bowel						
Constipation						
Light colored stool						
Loose stool/Diarrhea						
Nausea/vomiting						
Headaches/Migraines						
Body/Joint Aches						
Back Ache						
Acne						
Excessive facial hair						
Body/Head hair loss						
Dry skin/Brown spots						
Lowered Libido						
Heightened Libido						
Hot flashes						
Night sweats						
Breast tenderness/swelling						
Nipple discharge						
Vaginal infections						
Urinary frequency						
Incontinence						
Vaginal dryness						
Painful intercourse						

Any other symptoms? _____

_____

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 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 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 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: _____

_____

Have you been pregnant before? Yes No Age(s) of children: _____

Number of pregnancies? _____ Details/ Complications: _____

Number of live births: _____ _____

Miscarriages: _____ _____

Premature births: _____ _____

Cesarean births: _____ _____

Stillbirths: _____ _____

Abortions: _____ _____

Ectopic pregnancies _____ _____

If you have had a miscarriage, how many weeks pregnant were you? _____

_____

Did you breastfeed? Yes No How long? _____

Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: _____

Treatment and/or Medication: _____

Have you had a vaginal infection? Yes No If yes, what? _____

Treatment and/or Medication: _____

Any history of... Ovarian cysts? Yes No Uterine fibroids? Yes No

Fibrocystic Breasts? Yes No Endometriosis? Yes No

Polycystic Ovarian Syndrome (PCOS)? Yes No

FOR CYCLING-AGE WOMEN *(please fill in or circle the appropriate answer)*

First day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes No When? _____

Has there been any recent change in your cycle or 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* and/or *tampons* (circle) 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 abnormal vaginal discharge? Yes No If yes, when? _____

Do you experience vaginal itching and/or odor? 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

Do experience 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 *(uterus only)*

Date of hysterectomy: _____ Reason for hysterectomy: _____

_____

_____

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

_____

_____

_____

_____

_____

MENOPAUSAL WOMEN, CONT'D

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

If yes, what were you prescribed? _____

What dosage? _____ For how long? _____

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

If yes, what? _____

What dosage? _____ For how long? _____

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

If yes, what? _____

What dosage? _____ For how long? _____

Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No

If yes, when? _____ Were you evaluate and/or treated by a GYN? Yes No

Treatment: _____

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? _____

How many hours do you sleep a night on average? _____

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

Do you wake up tired? Yes No How long has this been happening? _____

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