Patient name: _____

FEMALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

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

1. What is the reason for this visit?

_____

_____

2. List medications you are currently taking:

_____

_____

3. Any known drug allergies? _____

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

_____

_____

_____

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

_____

_____

_____

6. Date of last pelvic/gynecological exam: _____ Last Pap Test: _____ Last mammogram: _____
7. Last thermography? _____ Unusual results? _____
8. List significant non-GYN health issues (diabetes, surgeries, etc.):

_____

_____

LIFESTYLE INDICATORS **< = less than > = greater than**

Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day	or stopped recently	_____(when?)
Coffee	None	<2 cups/day	>2 cups/day	or stopped recently	_____(when?)
Soda	None	<2 cans/day	>2 cans/day	or stopped recently	_____(when?)
Sweets/refined carbs		<twice/day	>twice/day	or stopped recently	_____(when?)

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? (circle) Y N Amount _____
3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10
5. How often do you exercise? never rarely sometimes regularly competitively

Patient name: _____

INSTRUCTIONS: Check either "Ongoing" or "Just w/ Period" for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity.

SIGNS & SYMPTOMS	ONGOING	JUST W/ PERIOD	MILD	MODERATE	SEVERE	MORE INFORMATION
Mood swings						
Anxiety/Nervousness/Irritable (circle)						
Overly Reactive/Short fuse/Anger (circle)						
Low Mood/Depression (circle)						
Low Blood Sugar/High Blood Sugar						
Lowered self-esteem/self-image (circle)						
Care for others before yourself						
Sadness/Crying (circle)						
Trouble Concentrating						
Memory difficulties						
Fatigue/Anemia (circle)						
Increased Appetite/Constant hunger (circle)						
Sweet cravings/Carbs/Chocolate (circle)						
Caffeine/Stimulant cravings (circle)						
Salt cravings						
Headaches/Migraines (circle)						
Muscle Pain/Joint Aches/Backache (circle)						
Weight gain/Trouble Losing Weight (circle)						
Weight loss						
Water Retention						
Bloating/Belching/Gas (circle)						
Stomach Burning/Nausea/Indigestion (circle)						
Constipation						
Light colored stool						
Loose stool/Diarrhea/IBS (circle)						
Acne/Rashes/Brown Spots (circle)						
Excessive facial hair/body hair (circle)						
Body/Head hair loss (circle)						
Infertility						
Lowered libido/Heightened libido (circle)						
Hot flashes/Night Sweats (circle)						
Palpitations						
Breast tenderness/Breast cysts (circle)						
Nipple discharge						
Vaginal infections/Yeast Infections (circle)						
Urinary Frequency/ Incontinence/Infections (circle)						
Dry eyes/Dry skin/Overall dryness (circle)						
Changes to Labia/Clitoral tissue (atrophy, thinning, discoloration, itching, burning) (circle)						
Vaginal changes (dryness, tearing, decreasing size) (circle)						

Any other symptoms? _____

Patient name: _____

REPRODUCTIVE HEALTH HISTORY *(please fill in or circle the appropriate answer)*

1. Age at onset of menarche (first period): _____ Approximate date of onset: _____
2. Are you currently using a method of birth control? Yes No
   If yes, what method? _____
3. Are you, or have you used *(please circle)* oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception (aka "the day after" pill)? Yes No
   When and for how long? _____
4. 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 _____
5. 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.)*

   _____

   _____

   _____
6. Have you used, or are you currently using fertility or treatment? Yes No
   If yes, please explain. _____
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, what hormone(s), dosage, & for how long? (Specify dates of use)

   _____

8. Are you trying to get pregnant? Yes No
9. 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 _____ _____

10. If you have had a miscarriage, how many weeks pregnant were you? _____
11. Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: _____
    Treatment and/or Medication: _____
12. Have you had a vaginal infection? Yes No If yes, what? _____
    Treatment and/or Medication: _____
13. Any history of... Ovarian cysts? Yes No Uterine fibroids? Yes No
    Fibrocystic Breasts? Yes No Endometriosis? Yes No
    Polycystic Ovarian Syndrome (PCOS)? Yes No Lichen Sclerosis? Yes No
    Vulvodynia? Yes No

Patient name: _____

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

1. First day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes No When? _____
2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No
   If yes, please give details. _____
3. 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 _____
4. How many days does menstruation typically last? _____
5. Is your cycle regular? Yes No Not Always Details: _____
6. Typical menstrual flow: Light Medium Heavy Details: _____
7. How many *pads* and/or *tampons* (circle) are used on heavy days? _____
8. Do you pass clots? Yes No How often? _____
9. Do you spot? Yes No At what point in your cycle? _____
10. Do you experience cramping? None Mild Moderate Severe
    At what point in your cycle? _____
11. Do you experience abnormal vaginal discharge? Yes No If yes, when? _____
12. Do you experience vaginal itching and/or odor? Yes No If yes, when? _____
13. Do you experience breast tenderness? None Mild Moderate Severe
    At what point in your cycle? _____ Change in breast size? Yes No
14. Do experience nipple discharge? Yes No If yes, when? _____ Color? _____

FOR MENOPAUSAL WOMEN *(please fill in or circle the appropriate answer)*

1. Your age at the onset of menopause: _____ Year of onset: _____
2. Have you had a hysterectomy? Complete *(ovaries AND uterus)* Partial *(uterus only)*
3. Date of hysterectomy: _____ Reason for hysterectomy: _____
4. List any other GYN related surgeries: _____
5. Describe your experience transitioning into menopause *(symptoms, strong emotions, thoughts, unusual stressors, etc.)*

MENOPAUSAL WOMEN, CONT'D

6. 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? _____
7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Yes No
   If yes, what? _____
   What dosage? _____ For how long? _____
8. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No
   If yes, what? _____
   For how long? _____
9. 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.

10. How would you have described your menstruation?
    Easy Uncomfortable Difficult Debilitating
11. What was your typical menstrual flow? Light Medium Heavy
12. When you were cycling would you consider your cycle regular? Yes No
    If no, explain. _____

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

_____

_____

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia
   How long has this been happening? _____
2. How many hours do you sleep a night on average? _____
3. Do night sweats wake you up? Yes No How often? _____
4. Do you wake up tired? Yes No How long has this been happening? _____
5. Is your room completely dark when you sleep at night? *(no night light, street lamp, TV, etc.)* Yes No
6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No