Patient name: _____

FEMALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

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

1. What is the reason for this visit?* What is your main concern?

_____

_____

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** * Indicate exact amount per day or week—

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

you must circle answer in first column, check either Ongoing or Just w/ Period for both AND rate Severity *

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?** _____