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? ☐ Yes ☐ No

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. Dates 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

1. Do you use any of the following? Check those that apply:

☐ Alcohol	☐ <2 drinks a day	☐ >2 drinks a day	
☐ Coffee	☐ <2 drinks a day	☐ >2 drinks a day	
☐ Sodas	☐ <2 drinks a day	☐ >2 drinks a day	
☐ Sweets/refined carbs	☐ <2 drinks a day	☐ >2 drinks a day	

2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often?
3. How would you rate your stress level on a scale between 1-10? (1= Low, 10=Extreme)
4. How would you rate your stress handling on a scale between 1-10? (1= Poor, 10 +Excellent)
5. How often do you exercise?

Instructions: Check either “Ongoing” or “Just w/Period” for each problem that applies to you. Check both problem if 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						
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						
Headache/Migraines						
Body/Join Aches/Backache						
Weight Gain						
Weight Loss						
Water Retention						
Bloating						
Irritable Bowel						
Constipation						
Light Colored Stool						
Loose Stool/Diarrhea						
Nausea/Vomiting						
Acne						
Excessive Facial Hair						
Body/Head Hair Loss						
Dry skin/Brown Spots						
Lowered Libido						
Heightened Libido						
Hot Flashes						
Night Sweets						
Breast Tenderness/Swelling						
Nipple Discharge						
Vaginal Infections						
Urinary Frequency						
Incontinence						
Vaginal Dryness						
Painful Intercourse						
Any other symptoms?						

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

1. Age at onset of menarche (first period): Approximate date of onset:
2. Are you currently using any method of birth control? ☐ Yes ☐ No
   If yes, what method?

3. Are you, or have you used oral. Injected, patch, or ring hormone contraceptives or used Emergency Contraceptive (the day after pill)? ☐ Yes ☐ No
   If yes, what type, when and for how long?

4. Are you, or have you used an IUD? ☐ Yes ☐ No If yes, when and for how long?

5. Please describe problem 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, palpations, etc.)

6. Have you used, or are you currently using fertility drugs or treatments? ☐ Yes ☐ No

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?
8. Have you been pregnant before? ☐ Yes ☐ No Ages of children:
   Number of pregnancies: Details complications:
   Number of live births:
   Miscarriages:
   Premature births:
   Cesarean births:
   Stillbirths:
   Abortions:
   Ectopic pregnancies:
9. If you have had a miscarriage, how many weeks pregnant were you?

10. Have you had an abnormal Pap Test? ☐ Yes ☐ No Diagnosis/Reason:

11. Have you had a vaginal infection? ☐ Yes ☐ No If yes, what?
    Treatment and/or medication:

12. 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 the appropriate answer)

1. First day of menstrual period (LMP): Have you had a tubal ligation? ☐ Yes ☐ No
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 in your current cycle? (count from the first day of your period to the first day of your next period.)
4. How many days does menstruation typically last?
5. Is your cycle regular? ☐ Yes ☐ No Details
6. Typical menstrual flow: ☐ Light ☐ Medium ☐ Heavy
7. How many pads and or tampons 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
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? Any change ion breast size? ☐ Yes ☐ No
14. Do you experience nipple discharge? ☐ Yes ☐ No If yes, when? Color?

FOR MENOPAUSAL WOMEN (please fill in the appropriate answer)

1. Your age at the onset of menopause: Year of onset:
2. Have you had a hysterectomy? Yes No 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.)

6. Have you used or are you currently using conventional hormone replacement therapy (HRT)? Yes No
7. Have you used, or are you using bioidentical hormone creams/sublingual, 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 evaluated and/or treated by a GYN? Yes No
   Treatment:

PLEASE DESCRIBE YOUR CYCLE HISTORY

10. How would you describe your menstruation?
    Easy Uncomfortable Difficult Debilitating
11. What was your typical menstrual flow? Low 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 then been happening?
5. Is your room completely dark when you sleep at night? (no night light, streetlamp, tv, etc.) ☐Yes ☐NO
6. Do you get at least 30 minutes of outside daylight time, several days a week? ☐Yes ☐No