

# FEMALE HEALTH HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ Age: \_\_\_\_\_ Today's date: \_\_\_\_\_

Address: \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

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

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

Alcohol None <2 drinks/day >2 drinks/day

Coffee None <2 cups/day >2 cups/day

Soda None <2 cans/day >2 cans/day

Sweets/refined carbs <twice/day >twice/day

2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often?

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

**Female History Questionnaire - B -**

**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				
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)				
Caffeine/Stimulant cravings				
Salt cravings				
Headaches/Migraines				
Body/Joint 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 sweats				

Breast tenderness/swelling
Nipple discharge
Vaginal infections
Urinary frequency
Incontinence
Vaginal dryness
Painful intercourse
<b>Any other symptoms?</b>
_____
_____

**Female History Questionnaire - C -**

**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? \_\_\_\_\_

8. 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 \_\_\_\_\_

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:

Treatment and/or Medication: \_\_\_\_\_

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

**Female History Questionnaire - D -**

**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.)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Female History Questionnaire - E -  
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.

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**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