

Female Health History Questionnaire

GENERAL INFORMATION

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

EMAIL _____ @ _____ How did you hear about us? _____

Home Phone _____ Cell Phone _____

Age _____ Date of Birth _____ Height _____ Weight _____ Occupation _____

Are you pregnant? Yes _____ No _____ Are you breastfeeding? Yes _____ No _____

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Medication/Supplement/Food

Reaction

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes _____ No _____ If yes, please list. _____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes _____ No _____ If yes, how many? _____

If yes, please list which kinds. _____

How long have you had these fillings? _____

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes _____ No _____

Have you had any dental work done in the last 12 months? Yes _____ No _____

MEDICATIONS & SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?

Yes ____ No ____ If yes, please describe: _____

SLEEP/REST

Average number of hours you sleep >10 8 – 10 6 – 8 <6

Do you have trouble falling asleep? Yes ____ No ____

Do you feel rested upon awakening? Yes ____ No ____

Do you have problems with insomnia? Yes ____ No ____

Do you snore? Yes ____ No ____

Do you use sleeping aids? Yes ____ No ____ Explain: _____

LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? Yes ____ No ____ How many years? ____ Packs per day: _____

If yes, what type? Cigarette ____ Smokeless ____ Cigar ____ Pipe ____ Patch/Gum ____

Previous smoking: How many years? ____ Packs per day: _____

Are you exposed to 2nd hand smoke? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None ____ 1-3 ____ 4-6 ____ 7-10 ____ >10 ____

Previous alcohol intake? Yes ____ (Mild ____ Moderate ____ High ____)

CAFFEINE INTAKE

How many cups of coffee per day? None ____ 1-3 ____ 4-6 ____ 7-10 ____

How many cans of soda per day? None ____ 1-3 ____ 4-6 ____ 7-10 ____

Is the soda you drink, diet soda? Yes ____ No ____

PREGNANCY HISTORY (Check box if yes and provide number of)

- Pregnancies _____ Caesarean _____ Vaginal deliveries _____
 Miscarriage _____ Abortion _____ Living Children _____
 Post partum depression Toxemia Gestational diabetes
 Baby over 8 pounds Breast feeding For how long? _____

FOR THE CYCLIC-AGE WOMAN

- Age at 1st period: _____ Menses Frequency: _____ Length of period: _____ Pain: Yes _____ No _____
Clotting: Yes _____ No _____ Has your period skipped? _____ For how long? _____
Last Menstrual Period: _____ How many days is your current cycle?
Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?
 Condom Diaphragm IUD Partner vasectomy
Have you ever used hormonal contraception? Yes _____ No _____ If yes, when _____
Use of hormonal contraception: Birth control pills Patch/Injection Nuva Ring
Are you using the pill now? Yes _____ No _____ Did taking the pill agree with you? Yes _____ No _____
In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes No
Date of last Mammogram _____ Breast Biopsy/Date _____
Last PAP Test: _____ Normal _____ Abnormal _____
Other information for us to know: _____

FOR THE WOMAN IN MENOPAUSE

- Age at onset of menopause: _____ Year of onset of menopause: _____
When you were cycling, would you consider your cycle regular? Yes _____ No _____
If no, why? _____
When you were cycling, what was your typical menstrual flow? Light _____ Medium _____ Heavy _____
Have you had a hysterectomy? Complete (ovaries and uterus) _____ Partial (uterus only) _____
Date of hysterectomy _____ Reason for hysterectomy: _____
Date of last Mammogram _____ Breast Biopsy/Date _____
Date of last Bone Density _____ Results: High Low Within normal range
Are you in menopause? Yes _____ No _____ Age at Menopause _____
Do you take: Estrogen Ogen Estrace Premarin Progesterone
 Provera Other _____
How long have you been on hormone replacement? _____
Other information for us to know: _____

SYMPTOMS

SYMPTOMS	Mild	Moderate	Severe	Additional Comments
Body/joint aches				
Weight gain				
Weight loss				
Elevated blood pressure				
Elevated cholesterol				
Digestive problems				
Head hair loss				
Dry skin/thinning skin				
Constant hunger				
Sweet cravings				
Caffeine cravings				
Salt cravings				
Anger/Aggression				
Irritability				
Low mood/Depression				
Concentration problems				
Foggy thinking				
Increased fatigue				
Lowered Libido				
Erectile Dysfunction				
Frequent need to urinate				
Pain with urination				
Bone loss/osteoporosis				
Low blood sugar				
Other				