WOMEN'S HEALTH QUESTIONNAIRE

General Information

Name_____ Date_____

Date of Birth_____ Age_____ Height _____ Weight_____

Primary Phone_____ Email _____

Address_____ Apt/Ste_____

City_____ State_____ Zip_____

Occupation _____ ☐ Full Time ☐ Part Time ☐ Retired ☐ Unemployed

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Other

Living Situation ☐ Spouse ☐ Alone ☐ Partner ☐ Parents ☐ Children ☐ Other _____

Pets? _____

How did you hear about Bio-Identical Hormone Replacement Therapy?

☐ Another Patient ☐ Books/Articles ☐ Course/Seminar ☐ Ads

☐ Physician/Healthcare ☐ Pharmacy Solutions ☐ Other

Please describe your current level of understanding of Bio-Identical Hormone Replacement Therapy.

_____

_____

Please list some health goals you have with the help of Bio-Identical Hormone Replacement Therapy.

_____

_____

_____

WOMEN'S HEALTH QUESTIONNAIRE

General Health Information

How would you rate your current general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current diagnosis and medical conditions _____

Drug allergies _____

Allergies to food, pollens, etc. _____

Current medications _____

Current vitamins/OTC products _____

Current herbs, etc. _____

Have you ever had your cholesterol level checked? ☐ No ☐ Yes, Date _____ Results _____

Have you ever had a mammogram? ☐ No ☐ Yes, Date _____ Results _____

Have you ever had a bone density scan? ☐ No ☐ Yes, Date _____ Results _____

Current/Recent Health Care Provider(s)_____

Medical History Information

Please check any past or current medical conditions that that apply to you.

☐ Childhood Disease _____

☐ Cardiovascular Disease _____

☐ Cancer _____

☐ Other _____

☐ Arthritis
☐ Asthma / COPD
☐ Chronic Fatigue
☐ Clotting Defects
☐ Cron's/Colitis
☐ Depression
☐ Diabetes
☐ Eating Disorder
☐ Epilepsy
☐ Fibromyalgia
☐ Fractures
☐ Gallbladder Trouble
☐ High Blood Pressure
☐ High Cholesterol
☐ Insomnia
☐ Kidney Trouble
☐ Malnutrition
☐ Osteoporosis
☐ Stroke
☐ Varicose Veins

WOMEN'S HEALTH QUESTIONNAIRE

Family Medical History

Please list family members and their age who are *still living* that have health conditions such as:
High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, Etc.

_____

_____

_____

Please list family members who died and their *age at death* of health conditions such as:
High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, Etc.

_____

_____

_____

Current Lifestyle & Habits

Please describe any dietary restrictions _____
Common Meal Choices:

Breakfast _____

Lunch _____

Dinner _____

Do you get routine physical exercise? ☐ No ☐ Yes, what type _____

Do you use tobacco products? ☐ No ☐ Yes, how much? _____ ☐ Previously, how long? _____

Do you use alcohol products? ☐ No ☐ Yes, how much? _____ ☐ Previously, how long? _____

Do you use caffeine products? ☐ No ☐ Yes, how much? _____ ☐ Previously, how long? _____

WOMEN'S HEALTH QUESTIONNAIRE

Gynecological History

Date of last pelvic exam _____ Results _____

Date of last pap-smear _____ Results _____

Have you ever had an abnormal pap-smear? ☐ No ☐ Yes, treatment _____

Are you sexually active? ☐ No ☐ Yes **Are you trying to get pregnant?** ☐ No ☐ Yes

Current birth control method _____ Problems with it? _____ How long? _____

Past birth control and any related problems _____

Age of first period _____ Date of last period _____

How many days from start of one period to the start of the next? _____

Number of days of flow _____ Amount of Bleeding _____ Amount of cramps _____

Premenstrual symptoms _____ Start & end when? _____

Any current changes in your normal cycle? ☐ No ☐ Yes, explain _____

Any bleeding between periods? ☐ No ☐ Yes, when? _____

Any pelvic pain, pressure or fullness? ☐ No ☐ Yes, describe _____

Any unusual vaginal discharge or itching? ☐ No ☐ Yes, describe _____ Treatment? _____

Age at first pregnancy _____ How many full-term pregnancies? _____

Pregnancy problems? _____

Any iterated pregnancies (miscarriages or abortions)? ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes, when? _____

Have you had any part of or a whole ovary removed? ☐ No ☐ Yes

Have you had a hysterectomy? ☐ No ☐ Yes, when? _____

Do your ovaries remain? ☐ No ☐ Yes

WOMEN'S HEALTH QUESTIONNAIRE

General Health Evaluation

Have you experienced any of the following recently? Circle the number that best describes your experiences on a scale 0 - 10.
(For example: 0 = non-existent, 1 = very mild, 10 = extremely severe)

Severity	**None**										**Extreme**
Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Fluid Retention	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:											
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10