

Female History Questionnaire

Name _____ Age: _____ Today's date: _____

D.O.B. _____ Weight: _____ Height: _____ Occupation: _____

What is the reason for your visit?

List any medications you are currently taking:

List any natural supplements or remedies you are currently taking:

1. At what age did you begin menstruating (onset of menarche)? _____

a. Number of days of cycle: _____

b. How many days of bleeding: _____

2. Have you ever been pregnant? Y/N How many times? _____

3. Do you have children? Y/N

a. How many? _____ Ages _____

4. Have you had any miscarriages or ectopic pregnancies? Y/N When? _____

5. Have you used oral, injected, or patch contraceptives? (Circle those that apply)

a. When & How Long? _____

b. For what reason?

6. Do you have any discomfort, PMS, or other symptoms around the time of your period?

7. Bleeding problems:

a. Heavy bleeding Y/N If Yes, how many days? _____

(Heavy bleeding is indicated if you saturate tampons or pads more than 4 times per day)

b. Spotting Y/N If yes, how many days? _____

c. Clotting Y/N

d. Cramping Y/N If yes, when? _____

e. Other _____

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8. List GYN procedures or surgeries: Ovaries, hysterectomy, breast, other—When and Why:

9. Significant health problems: _____

a. Illnesses _____

b. Surgical procedures _____

c. Hospitalizations _____

d. Other _____

10. Do you drink more than 2 alcoholic beverages per day? _____

11. Do you smoke? _____ How much? _____

Place a check next to the symptoms that apply to you.

1. ___ Mood swings ___ Mild ___ Moderate ___ Severe

2. ___ Irritability ___ Mild ___ Moderate ___ Severe

3. ___ Anxiety; Nervous tension ___ Mild ___ Moderate ___ Severe

4. ___ Short fuse ___ Severe temper ___ Rage ___ Aggression

5. ___ Overly sensitive

6. ___ I take care of everyone else in my life before myself

7. ___ Depression ___ Mild ___ Moderate ___ Severe

8. ___ Lessened self-esteem or self-image

9. ___ Sadness ___ Crying

10. ___ Bloating ___ Water Retention

11. ___ Memory difficulties ___ Foggy thinking ___ Lack of concentration

12. ___ Sweet cravings, Carbohydrate cravings, chocolate cravings worse before menses

13. ___ Candida (yeast infections)

14. ___ Hypoglycemia

15. ___ Hyperglycemia (diabetes)

16. ___ Weight gain ___ Overweight

17. ___ Weight loss

18. ___ Fatigue

19. ___ Cold hands and feet

20. ___ Change in bowel habits ___ Constipation ___ Diarrhea

21. ___ Muscle / joint aches and pains

22. ___ Back ache

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23. ____ Headaches / Migraines
a. When & How often? _____
b. Are they at specific times in your cycle? _____
24. ____ Nausea; vomiting
25. ____ Acne ____ Oily skin
26. ____ Excessive facial hair ____ Excessive body hair
27. ____ Change in libido ____ Decreased ____ Increased
28. ____ Difficulty sleeping ____ Insomnia
29. ____ Hot flashes
30. ____ Night sweats
31. ____ Dry eyes
32. ____ Vaginal dryness ____ Painful intercourse
33. ____ Urinary frequency ____ Urinary incontinence
34. Any other related symptoms or concerns not covered above?
