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.

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

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

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.

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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.

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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