

## FEMALE QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age of First Period: \_\_\_\_\_ Age of Last Period: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_ Born Children: \_\_\_\_\_ Age of 1<sup>st</sup> Pregnancy: \_\_\_\_\_

Age of Last Pregnancy: \_\_\_\_\_ Number of Miscarriages/Terminated Pregnancies: \_\_\_\_\_

When was your last period? \_\_\_\_\_ How long did it last? \_\_\_\_\_

Date of last Mammogram? \_\_\_\_\_ Where did you have it done? \_\_\_\_\_

Date of last Pap Smear \_\_\_\_\_ Name of Doctor who performed Pap \_\_\_\_\_

Do you suffer from PMS or PMDS? YES NO

Have you been on any SSRI'S (antidepressants)  Prozac  Zoloft  Wellbutrin If so, for how long? \_\_\_\_\_

**REVIEW OF SYMPTOMS** – Please check the box next to any symptoms that you have been experiencing

<b>GENERAL</b>	<input type="checkbox"/> Loss of energy / weakness <input type="checkbox"/> Decreased flexibility <input type="checkbox"/> Stress	<input type="checkbox"/> Fatigue / tiredness <input type="checkbox"/> Weight gain in breast/hips/waist	<input type="checkbox"/> Loss of Fitness <input type="checkbox"/> Adult Mumps <input type="checkbox"/> Rapid aging	<input type="checkbox"/> Burned out feeling <input type="checkbox"/> Decreased stamina
<b>SKIN</b>	<input type="checkbox"/> Wrinkles <input type="checkbox"/> Brittle nails <input type="checkbox"/> Rashes	<input type="checkbox"/> Dry skin / Dry hair <input type="checkbox"/> Thinning skin <input type="checkbox"/> Itching	<input type="checkbox"/> Morning and evening fatigue <input type="checkbox"/> Oily skin <input type="checkbox"/> Lesions	<input type="checkbox"/> Hypothermia <input type="checkbox"/> Acne
<b>HEAD</b>	<input type="checkbox"/> Trauma	<input type="checkbox"/> Headaches	<input type="checkbox"/> Tenderness	
<b>EYES</b>	<input type="checkbox"/> Swelling/Puffiness <input type="checkbox"/> Discharge	<input type="checkbox"/> Change in visual field <input type="checkbox"/> Inflammation	<input type="checkbox"/> Sensitivity to light <input type="checkbox"/> Use of glasses	<input type="checkbox"/> Double Vision
<b>EARS</b>	<input type="checkbox"/> Ringing in ears <input type="checkbox"/> Discharge	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Hearing Changes	<input type="checkbox"/> Pain
<b>NOSE</b>	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Obstructive polyps	<input type="checkbox"/> Deviated septum
<b>THROAT</b>	<input type="checkbox"/> Goiter <input type="checkbox"/> Lesions	<input type="checkbox"/> Hoarseness <input type="checkbox"/> Discharge	<input type="checkbox"/> Dentures	<input type="checkbox"/> Inflammation
<b>RESPIRATORY</b>	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing up blood
<b>CARDIOVASCULAR</b>	<input type="checkbox"/> Hypertension <input type="checkbox"/> Bradycardia <input type="checkbox"/> Murmurs	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitations <input type="checkbox"/> Short of Breath	<input type="checkbox"/> Tachycardia <input type="checkbox"/> Rheumatic fever
<b>GASTROINTESTINAL</b>	<input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea	<input type="checkbox"/> Decreased Appetite <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Constipation	<input type="checkbox"/> Problem Swallowing <input type="checkbox"/> Indigestion <input type="checkbox"/> Black Stool	<input type="checkbox"/> Nausea <input type="checkbox"/> Pain <input type="checkbox"/> Hemorrhoid
<b>GENITOURINARY (BOTH)</b>	<input type="checkbox"/> Loss of libido or sex drive <input type="checkbox"/> Frequency <input type="checkbox"/> Nocturia	<input type="checkbox"/> Delayed orgasm or decreased intensity <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence	<input type="checkbox"/> Discomfort during sex <input type="checkbox"/> Dysuria	<input type="checkbox"/> Infertility problems <input type="checkbox"/> Hematuria
<b>GENITOURINARY (FEMALE)</b>	<input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Breakthrough Bleeding <input type="checkbox"/> Oophorectomy / Hysterectomy	<input type="checkbox"/> Vaginal itching <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Hot flashes	<input type="checkbox"/> Decreased vaginal lubrication <input type="checkbox"/> Cramps <input type="checkbox"/> Night sweats	<input type="checkbox"/> Fibrocystic breast <input type="checkbox"/> Heavy/Irregular Menses <input type="checkbox"/> Decreased arm/leg hair growth
<b>ENDOCRINE</b>	<input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Excessive Urination	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> Decreased sweating <input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Hair loss/thinning/oily <input type="checkbox"/> Problem Swallowing <input type="checkbox"/> Hormone Therapy	<input type="checkbox"/> Crave Sugar <input type="checkbox"/> Increased Thirst

<b>SKELETOMUSCULAR</b>	<input type="checkbox"/> Arthritis <input type="checkbox"/> Decreased flexibility	<input type="checkbox"/> Backache/Joint pain/Stiffness <input type="checkbox"/> Neck/Back pain	<input type="checkbox"/> Decreased muscle size <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Sore muscles
<b>HEMATOLOGY</b>	<input type="checkbox"/> Anemia	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Easy bruising	
<b>NEUROLOGICAL</b>	<input type="checkbox"/> Loss of memory/concentration <input type="checkbox"/> Decreased mental sharpness <input type="checkbox"/> Syncope	<input type="checkbox"/> Dizziness <input type="checkbox"/> Mental fatigue <input type="checkbox"/> Seizures	<input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Numbness hands/feet <input type="checkbox"/> Weakness	<input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Vertigo <input type="checkbox"/> Coordination problems
<b>PSYCHIATRIC</b>	<input type="checkbox"/> Anxiety and/or nervousness <input type="checkbox"/> Tearfulness	<input type="checkbox"/> Depression <input type="checkbox"/> Mood swings	<input type="checkbox"/> Low or negative mood <input type="checkbox"/> Apathy	<input type="checkbox"/> Irritability or bad temper <input type="checkbox"/> Aggressive behavior
<b>RENAL</b>	<input type="checkbox"/> Fluid retention			

<b>PATIENT HISTORY</b>	<b>NO</b>	<b>YES - EXPLAIN</b>	<b>PATIENT HISTORY</b>	<b>NO</b>	<b>YES - EXPLAIN</b>
Heart Disease			Blood Clotting Problems		
High Cholesterol			Diabetes		
High Blood Pressure			Arthritis/Joint Problems		
Cancer			Depression		
Ulcers			Epilepsy		
Thyroid Disease			Headaches/Migraines		
Hormonal Related Issues			Eye Disease		
Lung Conditions			HIV		
Hepatitis A, B or C			Lupus		
Chronic Fatigue Syndrome			Liver Condition		
Fibromyalgia			Other		
ALLERGIES: Medications			ALLERGIES: Foods		
ALLERGIES: Other					

What are your expectations from our services? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any questions you may have: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_