

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? Yes No

Email address: _____ May we contact you via email? Yes No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): Married Divorced Widow Living with partner Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

- | | | | |
|--|----|--|---|
| <input type="checkbox"/> I am sexually active. | OR | <input type="checkbox"/> I want to be sexually active. | <input type="checkbox"/> I do not want to be sexually active. |
| <input type="checkbox"/> I have completed my family. | OR | <input type="checkbox"/> I have NOT completed my family. | |
| <input type="checkbox"/> My sex life has suffered. | OR | <input type="checkbox"/> I have not been able to have an orgasm or it is very difficult. | |

Habits:

- | | | |
|--|---|--|
| <input type="checkbox"/> I smoke cigarettes or cigars _____ per day. | <input type="checkbox"/> I use e-cigarettes _____ a day. | <input type="checkbox"/> I use caffeine _____ a day. |
| <input type="checkbox"/> I drink alcoholic beverages _____ per week. | <input type="checkbox"/> I drink more than 10 alcoholic beverages a week. | |

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? Yes No Do you have a latex allergy? Yes No

Medications currently taking: _____

Current hormone replacement? Yes No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

Heart disease Diabetes Osteoporosis Alzheimer's/dementia Breast cancer Other _____

Pertinent medical/surgical history:

- | | |
|--|---|
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Fibrocystic breast or breast pain |
| <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Irregular or heavy periods |
| <input type="checkbox"/> Polycystic ovaries/PCOS | <input type="checkbox"/> Menstrual migraines |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Hysterectomy with removal of ovaries |
| <input type="checkbox"/> Excess facial/body hair | <input type="checkbox"/> Partial hysterectomy (uterus only) |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Oophorectomy removal of ovaries only |
| <input type="checkbox"/> Endometriosis | |
| <input type="checkbox"/> Epilepsy or seizures | |

Birth control method:

- Menopause
- Hysterectomy
- Tubal ligation
- Birth control pills
- Vasectomy
- IUD
- Infertility
- Other _____

Name: _____ Date of birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- | | |
|--|--|
| <input type="checkbox"/> High blood pressure or hypertension | <input type="checkbox"/> Stroke and/or heart attack |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> HIV or any type of hepatitis |
| <input type="checkbox"/> Atrial fibrillation or other arrhythmia | <input type="checkbox"/> Hemochromatosis |
| <input type="checkbox"/> Blood clot and/or a pulmonary embolism | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Chronic liver disease (hepatitis, fatty liver, cirrhosis) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Hair thinning | <input type="checkbox"/> Lupus or other autoimmune disease |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High cholesterol | |

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems (difficulty falling asleep or sleeping through the night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decline in drive or interest (loss of "zest for life," feeling down or sad)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory (concentration, finding the right word, or retaining information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness or difficulty with sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (night sweats or increased episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes (burst that starts in chest and lasts for short duration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss, thinning or change in texture of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling cold all the time, having cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or migraines (increase in frequency or intensity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight (difficulty losing weight despite diet/exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other symptoms or unique health circumstances to take into consideration:
