Female Patient Questionnaire & History

Habits:

( ) I smoke cigarettes or cigars_____ a day.
( ) I drink alcoholic beverages_____ per week.
( ) I drink more than 10 alcoholic beverages a week.
( ) I use caffeine_____ a day.

Medical History (if not listed on H&P)

Current Hormone Replacement
Therapy:_____

Past Hormone Replacement
Therapy:_____

Nutritional/Vitamin
Supplements:_____

Last menstrual cycle (estimate year if unknown):
_____

Other Pertinent
Information:_____

Preventative Medical Care:

Date of last pap smear:_____
Date of last Mammogram:_____
Date of last Bone Density:_____
Do you have a history of:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) None of Above
Have you had:
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy (removal of uterus only)
( ) Oophorectomy (Removal of Ovaries only)
Birth Control Method:
( ) Menopause.
( ) Hysterectomy.
( ) Tubal Ligation.
( ) Birth Control Pills.
( ) Vasectomy.
( ) Other:_____

( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer
(type):_____Year:_____

Please mark any **Medical Illnesses:**

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Female Patient Symptom Checklist

Please check all of your symptoms and indicate severity.

Symptom	Never	Mild	Moderate	Severe
Depressive Mood				
Fatigue				
Memory Loss				
Mental Confusion				
Decreased Sex Drive/ Libido				
Sleep Problems				
Mood Changes				
Irritability				
Tension				
Migraines/Headaches				
Difficult to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry and/or Wrinkled Skin				
Hair Loss				
Sensitivity to Cold				
Swelling				
Joint Pain				

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0=Never 1=Mild 2=Moderate 4=Severe

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