

Female Health History Questionnaire

GENERAL INFORMATION

Today's Date _____
 Name: Mr./Mrs./Ms. _____ Address _____
 Apt # _____ City _____ State ____ Zip _____ Home Phone () _____
 Work () _____ Cell () _____ Best place to reach you: Home Work Cell
 If necessary, may we leave a message for you at any of the above numbers? Yes / No
Email: _____ **SSN** _____
 Employer: _____ Occupation: _____
 Duration of Employment: _____ Age: ____ Date of Birth ____/____/____
 Sex: M F Martial Status: S M W Name (First/Last) of Spouse or Partner: _____
 Height _____ Weight _____ Occupation _____
 Are you pregnant? Yes ____ No ____ Are you breastfeeding? Yes ____ No ____
 Are you cyclic? Yes ____ No ____ Are you in Menopause? Yes ____ No ____

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes ____ No ____ If yes, please list. _____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes ___ No ___ If yes, how many? _____

If yes, please list which kinds. _____

How long have you had these fillings? _____

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes ___ No ___

Have you had any dental work done in the last 12 months? Yes ___ No ___

MEDICATIONS & SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?

Yes ___ No ___ If yes, please describe: _____

SLEEP/REST

Average number of hours you sleep >10 8-10 6-8 <6

Do you have trouble falling asleep? Yes ___ No ___

Do you feel rested upon awakening? Yes ___ No ___

Do you have problems with insomnia? Yes ___ No ___

Do you snore? Yes ___ No ___

Do you use sleeping aids? Yes ___ No ___ Explain: _____

LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? Yes ___ No ___ How many years? _____ Packs per day: _____

If yes, what type? Cigarette _____ Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____

Previous smoking: How many years? _____ Packs per day: _____

Are you exposed to 2nd hand smoke? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None ___ 1-3 ___ 4-6 ___ 7-10 ___ >10 ___

Previous alcohol intake? Yes ___ (Mild ___ Moderate ___ High ___)

CAFFEINE INTAKE

How many cups of coffee per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____

How many cans of soda per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____

Is the soda you drink, diet soda? Yes _____ No _____

PREGNANCY HISTORY (Check box if yes and provide number of)

Pregnancies _____ Caesarean _____ Vaginal deliveries _____

Miscarriage _____ Abortion _____ Living Children _____

Post partum depression Toxemia Gestational diabetes

Baby over 8 pounds Breast feeding For how long? _____

FOR THE CYCLIC-AGE WOMAN

Age at 1st period: _____ Menses Frequency: _____ Length of period: _____ Pain: Yes _____ No _____

Clotting: Yes _____ No _____ Has your period skipped? _____ For how long? _____

Last Menstrual Period: _____ How many days is your current cycle?

Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?

Condom Diaphragm IUD Partner vasectomy

Have you ever used hormonal contraception? Yes _____ No _____ If yes, when _____

Use of hormonal contraception: Birth control pills Patch/Injection Nuva Ring

Are you using the pill now? Yes _____ No _____ Did taking the pill agree with you? Yes _____ No _____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes No

Date of last Mammogram _____ Breast Biopsy/Date _____

Last PAP Test: _____ Normal _____ Abnormal _____

Other information for us to know: _____

FOR THE WOMAN IN MENOPAUSE

Age at onset of menopause: _____ Year of onset of menopause: _____

When you were cycling, would you consider your cycle regular? Yes _____ No _____

If no, why? _____

When you were cycling, what was your typical menstrual flow? Light _____ Medium _____ Heavy _____

Have you had a hysterectomy? Complete (ovaries and uterus) _____ Partial (uterus only) _____

Date of hysterectomy _____ Reason for hysterectomy: _____

Date of last Mammogram _____ Breast Biopsy/Date _____

Date of last Bone Density _____ Results: High Low Within normal range

Are you in menopause? Yes _____ No _____ Age at Menopause _____

