Questionnaire

Name:___________________________ Cell #: ______________________

Email:___________________________ Weight:_____________________

Age: _______________________

Referred by: __________________________

Are you still Menstruating?	Yes	No
Are you Pregnant?	Yes	No
Are you currently on HRT **(Hormone Replacement Therapy)**	Yes	No
Are you currently on Thyroid medication? _____________	Yes	No
Do you have Hashimoto's Disease?	Yes	No
Do you have Fibrocystic Breast Disease?	Yes	No
Do you have PCOS **(Polycystic Ovary Syndrome)**	Yes	No
Do you have Endometrial Polyps?	Yes	No
Do you have History of Breast Cancer?	Yes	No
Are you a smoker?	Yes	No

Do you suffer from the following symptoms?

Acne	Yes	No
Breast tenderness	Yes	No
Facial Hair	Yes	No
Pre-menstrual Migraines	Yes	No

Date of your last Pap-smear: _______________________ Abnormal? Yes No

Date of last Mammogram:_________________________ Abnormal? Yes No

Birth Control Method:

- ☐ **None**
- ☐ **Birth Control**
- ☐ **Abstinence**
- ☐ **IUD - Mirena**
- ☐ **IUD - Other**
- ☐ **Menopause**
- ☐ **Tubal Ligation**
- ☐ **Hysterectomy**
- ☐ **Other**