

WOMEN'S HEALTH QUESTIONNAIRE

General Information

Name _____

Date _____

Date of Birth _____ Age _____

Height _____ Weight _____

Primary Phone _____

Email _____

Address _____

Apt/Ste _____

City _____

State _____ Zip _____

Occupation _____ Full Time Part Time Retired Unemployed

Marital Status Married Single Divorced Other

Living Situation Spouse Alone Partner Parents Children Other _____

Pets? _____

How did you hear about Bio-Identical Hormone Replacement Therapy?

Another Patient Books/Articles Course/Seminar Ads

Physician/Healthcare Pharmacy Solutions Other

Please describe your current level of understanding of Bio-Identical Hormone Replacement Therapy.

Please list some health goals you have with the help of Bio-Identical Hormone Replacement Therapy.



WOMEN'S HEALTH QUESTIONNAIRE

General Health Information

How would you rate your current general health? Excellent Good Fair Poor

Current diagnosis and medical conditions _____

Drug allergies _____

Allergies to food, pollens, etc. _____

Current medications _____

Current vitamins/OTC products _____

Current herbs, etc. _____

Have you ever had your cholesterol level checked? No Yes, Date _____ Results _____

Have you ever had a mammogram? No Yes, Date _____ Results _____

Have you ever had a bone density scan? No Yes, Date _____ Results _____

Current/Recent Health Care Provider(s) _____

Medical History Information

Please check any past or current medical conditions that that apply to you.

Childhood Disease _____

Cardiovascular Disease _____

Cancer _____

Other _____

Arthritis

Eating Disorder

Insomnia

Asthma / COPD

Epilepsy

Kidney Trouble

Chronic Fatigue

Fibromyalgia

Malnutrition

Clotting Defects

Fractures

Osteoporosis

Cron's/Colitis

Gallbladder Trouble

Stroke

Depression

High Blood Pressure

Varicose Veins

Diabetes

High Cholesterol



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Family Medical History

Please list family members and their age who are *still living* that have health conditions such as:
High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, Etc.

Please list family members who died and their *age at death* of health conditions such as:
High Blood Pressure, Heart Disease, Cancer, Diabetes, Osteoporosis, Etc.

Current Lifestyle & Habits

Please describe any dietary restrictions _____

Common Meal Choices:

Breakfast _____

Lunch _____

Dinner _____

Do you get routine physical exercise? No Yes, what type _____

Do you use tobacco products? No Yes, how much? _____ Previously, how long? _____

Do you use alcohol products? No Yes, how much? _____ Previously, how long? _____

Do you use caffeine products? No Yes, how much? _____ Previously, how long? _____



WOMEN'S HEALTH QUESTIONNAIRE

Gynecological History

Date of last pelvic exam _____ Results _____

Date of last pap-smear _____ Results _____

Have you ever had an abnormal pap-smear? No Yes, treatment _____

Are you sexually active? No Yes Are you trying to get pregnant? No Yes

Current birth control method _____ Problems with it? _____ How long? _____

Past birth control and any related problems _____

Age of first period _____ Date of last period _____

How many days from start of one period to the start of the next? _____

Number of days of flow _____ Amount of Bleeding _____ Amount of cramps _____

Premenstrual symptoms _____ Start & end when? _____

Any current changes in your normal cycle? No Yes, explain _____

Any bleeding between periods? No Yes, when? _____

Any pelvic pain, pressure or fullness? No Yes, describe _____

Any unusual vaginal discharge or itching? No Yes, describe _____ Treatment? _____

Age at first pregnancy _____ How many full-term pregnancies? _____

Pregnancy problems? _____

Any iterated pregnancies (miscarriages or abortions)? No Yes

Have you had a tubal ligation? No Yes, when? _____

Have you had any part of or a whole ovary removed? No Yes

Have you had a hysterectomy? No Yes, when? _____

Do your ovaries remain? No Yes



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General Health Evaluation

Have you experienced any of the following recently? Circle the number that best describes your experiences on a scale 0 - 10.
(For example: 0 = non-existent, 1 = very mild, 10 = extremely severe)

Severity	None										Extreme
Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of Recent Memory	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10
Decreased Sex Drive	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Fluid Retention	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Harder to Reach Climax	0	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:											
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

