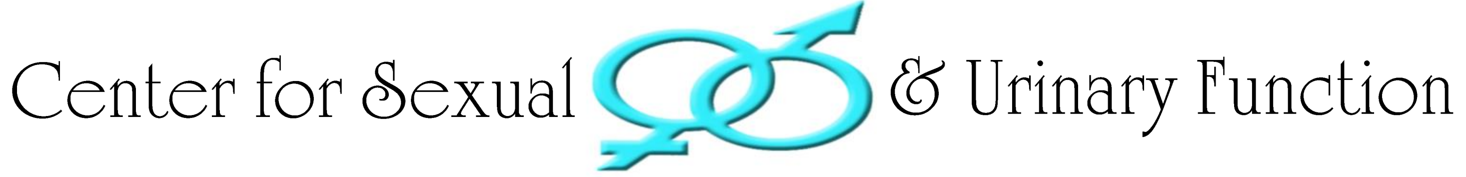

FEMALE Medical History Questionnaire

Have you had any of the following problems in the last year?

OBSTETRICAL Hx (LIFETIME)

Number of pregnancies ____
Number of childbirths ___
# of miscarriages/ abortions ___

- ☐ Menopause
- ☐ Menstruating
- ☐ Removal of uterus
- ☐ Removal of ovaries

GENERAL

- ☐ Excessive fatigue
- ☐ Unexplained loss of weight
- ☐ Chills or fever

NEUROLOGICAL

- ☐ Trouble sleeping
- ☐ Numbness or tingling
- ☐ Shooting pains

PSYCHIATRIC

- ☐ Worries or fears
- ☐ Depressed feelings
- ☐ Psychiatric care or treatment

EARS, NOSE AND THROAT

- ☐ Hearing loss
- ☐ Nose bleeds
- ☐ Blocked sinuses

EYES

- ☐ Changes in you sight
- ☐ Changes in your vision
- ☐ Glaucoma

RESPIRATORY SYSTEM

- ☐ Wheezing or asthma
- ☐ Shortness of breath
- ☐ Chronic persistent cough

CARDIOVASCULAR SYSTEM

- ☐ Chest pain or tightness
- ☐ Rapid or irregular heart beats
- ☐ High blood pressure
- ☐ Foot or ankle swelling

DIGESTIVE TRACT

- ☐ Nausea
- ☐ Heartburn
- ☐ Gas or bloating
- ☐ Constipation
- ☐ Diarrhea

BONES AND JOINTS

- ☐ Joint pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Broken bones

FEMALE & REPRODUCTIVE

- ☐ Sexually active
- ☐ Problems with sexual activity
(Request **FSFI** questionnaire)
- ☐ Pelvic organ prolapse
(Request **PFDI** questionnaire)
- ☐ Vaginal abnormality

UROLOGICAL

- ☐ Blood in the urine
- ☐ Problem urinating
- ☐ Involuntary urine leakage
(Request **UDI/IIQ** questionnaire)
- ☐ Pelvic pain/voiding problems
(Request **UPPI** questionnaire)
- ☐ Urinary infections
  - ☐ of bladder
  - ☐ of kidney
- ☐ Urinary stones
  - ☐ in kidney
  - ☐ in ureter
  - ☐ in bladder

SKIN

- ☐ Sensitive skin
- ☐ Skin rash
- ☐ Non healing sores

ENDOCRINE SYSTEM

- ☐ Excessive thirst
- ☐ Thyroid problems
- ☐ Steroid use
- ☐ Diabetes

LYMPH & HEMATOLOGICAL

- ☐ Anemia
- ☐ Easy bruising or bleeding
- ☐ Enlarged lymph glands
- ☐ Blood transfusion

PATIENT NAME	AGE