

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, anger easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

PATIENT INFORMATION

NAME: _____ TODAYS DATE: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

PATIENT QUESTIONS

CURRENTLY PREGNANT OR TRYING TO CONCEIVE? ☐ YES ☐ NO

HAD A RECENT MAMMOGRAM (WITHIN LAST 12 MONTHS)? ☐ YES ☐ NO

HAVE YOU HAD A HYSTERECTOMY? ☐ YES ☐ NO

IF SO, TYPE?: ☐ COMPLETE (UTERUS AND OVARIES REMOVED) ☐ PARTIAL (UTERUS ONLY REMOVED)

HAD MENSTRUAL CYCLE (WITHIN LAST 12 MONTHS)? ☐ YES ☐ NO

HAD ENDOMETRIAL ABLATION? ☐ YES ☐ NO

ARE YOU ON BIRTH CONTROL? ☐ YES ☐ NO

IF SO, TYPE & BRAND: _____

ARE YOU CURRENTLY UTILIZING BHRT OR HRT? ☐ YES ☐ NO

IF SO, TYPE/S OF HORMONES: ☐ TESTOSTERONE ☐ PROGESTERONE ☐ ESTROGEN ☐ THYROID

BRAND & DOSE OF HORMONES: _____

ARE YOU CURRENTLY ON STATINS? ☐ YES ☐ NO

ARE YOU A SMOKER? ☐ YES ☐ NO

ARE YOU CURRENTLY ON ORAL NITRATES? ☐ YES ☐ NO

MEDICAL HISTORY

SELECT ALL THAT APPLY

CARDIOVASCULAR CONDITIONS:

- ☐ HEART ATTACK OR STROKE (WITHIN LAST 6 MONTHS)
- ☐ TACHYCARDIA
- ☐ DVT OR BLOOD CLOT (WITHIN LAST 6 MONTHS)
- ☐ HYPERTENSION
- ☐ HYPERLIPIDEMIA
- ☐ OBSTRUCTIVE SLEEP APNEA
- ☐ ATRIAL FIBRILLATION

GYNECOLOGICAL CONDITIONS:

- ☐ PRE-MENSTRUAL SYNDROME (PMS)
- ☐ ENDOMETRIOSIS OR HISTORY OF ENDOMETRIOSIS
- ☐ FIBROCYSTIC BREAST DISEASE
- ☐ FIBROIDS OR HISTORY OF FIBROIDS
- ☐ POLYPS OR HISTORY OF ENDOMETRIAL POLYPS

ENDOCRINE & METABOLIC:

- ☐ PCOS
- ☐ DIABETES TYPE 2 OR INSULIN RESISTANCE
- ☐ HYPERTHYROID
- ☐ HYPOTHYROID
- ☐ MULTIPLE ENDOCRINE NEOPLASIA TYPE 2

CANCER:

- ☐ BREAST CANCER OR HISTORY OF BREAST CANCER
- ☐ ENDOMETRIAL CANCER
- ☐ CERVICAL CANCER
- ☐ OVARIAN CANCER
- ☐ THYROID CANCER OR HISTORY OF THYROID CANCER
- ☐ BASAL CELL CARCINOMA
- ☐ OTHER: _____

NEUROLOGICAL CONDITIONS:

- ☐ EPILEPSY OR SEIZURE DISORDER
- ☐ DEPRESSION OR ANXIETY
- ☐ PSYCHIATRIC CONDITIONS
- ☐ MIGRAINE WITH AURA
- ☐ MENINGIOMA

MEDICAL HISTORY

SELECT ALL THAT APPLY

AUTOIMMUNE CONDITIONS:

- ☐ DIABETES TYPE 1
- ☐ HASHIMOTO'S THYROIDITIS
- ☐ GRAVES' DISEASE
- ☐ RHEUMATOID ARTHRITIS
- ☐ MULTIPLE SCLEROSIS
- ☐ SYSTEMIC LUPUS (ERYTHEMATOSUS)
- ☐ PSORIASIS
- ☐ IRRITABLE BOWEL SYNDROME (IBS)
- ☐ CROHN'S DISEASE
- ☐ ULCERATIVE COLITIS

ORGAN SPECIFIC CONDITIONS:

- ☐ LIVER DISEASE OR HISTORY OF LIVER DISEASE
- ☐ KIDNEY DISEASE OR HISTORY OF KIDNEY DISEASE
- ☐ LAM (LYMPHANGIOLEIOMYOMATOSIS)
- ☐ OSTEOPOROSIS OR OSTEOPENIA
- ☐ HIV
- ☐ HEPATITIS
- ☐ HEMOCHROMATOSIS
- ☐ PANCREATITIS OR HISTORY OF PANCREATITIS
- ☐ GALL BLADDER DISEASE, OR HISTORY OF DISEASE
- ☐ POLYCYTHEMIA VERA (PV)

SYMPTOMS & CONCERNS

SELECT ALL THAT APPLY

- ☐ HOT FLASHES
- ☐ NIGHT SWEATS
- ☐ VAGINAL DRYNESS
- ☐ DECREASED LIBIDO
- ☐ DELAYED ORGASM, OR INABILITY TO
- ☐ PAINFUL INTERCOURSE
- ☐ URINARY INCONTINENCE
- ☐ FREQUENT URINARY TRACT INFECTION (UTI)
- ☐ BREAST TENDERNESS
- ☐ WEIGHT GAIN
- ☐ HAIR LOSS
- ☐ HAIR THINNING (INCLUDING EYEBROWS)

- ☐ COLD HANDS OR FEET
- ☐ BRITTLE NAILS
- ☐ DRY OR FLAKING SKIN
- ☐ LACK OF ENERGY (FATIGUE)
- ☐ DECREASED MUSCLE MASS
- ☐ ACNE
- ☐ FACIAL HAIR
- ☐ DRY EYES
- ☐ JOINT PAIN
- ☐ DIFFICULTY SLEEPING
- ☐ MIND RACING AT BEDTIME
- ☐ EATING WHEN STRESSED