Female Hormone History

(Replaces Premenopause Syndrome Questionnaire)

Name____ Age: ________

Date of Birth __________ Weight: _____ Occupation: ____________________

What is the reason for your visit?

____

____

____

List any medications you are currently taking:

____

____

List any natural supplements or remedies you are currently taking:

____

____

* *

1. At what age did you begin menstruating (onset of menarche)? ________
   a. Number of days of cycle: ________
   b. How many days of bleeding: __________
2. Have you ever been pregnant? Y/N How many times? ______
3. Do you have children? Y/N
   a. How Many? ____ Ages ________________
4. Have you had any miscarriages or ectopic pregnancies? Y/N When? ________
5. Have you used oral, injected, or patch contraceptives? (Circle those that apply)
   a. When & How Long? ____________________________
   b. For what reason?

   ____

   ____
6. Do you have any discomfort, PMS, or other symptoms around the time of your period?

   ____

   ____

   ____

   ____

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7. Bleeding problems:
   a. Heavy bleeding Y/N If Yes, how many days? _____
   (Heavy bleeding is indicated if you saturate tampons or pads more than 4 times per day)
   b. Spotting Y/N If yes, how many days? _____
   c. Clotting Y/N
   d. Cramping Y/N If yes, when? _____
   e. Other _____
8. List GYN procedures or surgeries: Ovaries, hysterectomy, breast, other—When and Why:
   _____
   _____
9. Significant health problems:_____
   a. Illnesses _____
   b. Surgical procedures _____
   c. Hospitalizations _____
   d. Other _____
10. Do you drink more than 2 alcoholic beverages per day? _____
11. Do you smoke? _____ How much? _____

Place a check next to the symptoms that apply to you.

1. _____ Mood swings _____ Mild _____ Moderate _____ Severe
2. _____ Irritability _____ Mild _____ Moderate _____ Severe
3. _____ Anxiety; Nervous tension _____ Mild _____ Moderate _____ Severe
4. _____ Short fuse _____ Severe temper _____ Rage _____ Aggression
5. _____ Overly sensitive
6. _____ I take care of everyone else in my life before myself
7. _____ Depression _____ Mild _____ Moderate _____ Severe
8. _____ Lessened self-esteem or self-image
9. _____ Sadness _____ Crying
10. _____ Bloating _____ Water Retention
11. _____ Memory difficulties _____ Foggy thinking _____ Lack of concentration
12. _____ Sweet cravings, Carbohydrate cravings, chocolate cravings worse before menses
13. _____ Candida (yeast infections)
14. _____ Hypoglycemia
15. _____ Hyperglycemia (diabetes)

16._____ Weight gain _____ Overweight

17._____ Weight loss

18._____ Fatigue

19._____ Cold hands and feet

20._____ Change in bowel habits _____ Constipation _____ Diarrhea

21._____ Muscle / joint aches and pains

22._____ Back ache

23._____ Headaches / Migraines

a. When & How often? _____

b. Are they at specific times in your cycle? _____

24._____ Nausea; vomiting

25._____ Acne _____ Oily skin

26._____ Excessive facial hair _____ Excessive body hair

27._____ Change in libido _____ Decreased _____ Increased

28._____ Difficulty sleeping _____ Insomnia

29._____ Hot flashes

30._____ Night sweats

31._____ Dry eyes

32._____ Vaginal dryness _____ Painful intercourse

33._____ Urinary frequency _____ Urinary incontinence

34. Any other related symptoms or concerns not covered above?

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