**PERSONAL INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_

Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of spouse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY NOTIFICATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT**

I understand that all services are rendered on a cash or check basis. Unless other arrangements

have been made and approved, I agree to pay for each session at the time of the session. I also agree to the

$20 returned check charge in the event that your check is returned.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CURRENT HEALTH CONDITION**

Primary Purpose of this consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HABITS (Please circle responses):**

Alcohol: None Less than 2 drinks per day Greater than 2 drinks per day or stopped recently \_\_\_\_\_\_\_\_\_\_\_\_

Caffeine: None Less than 2 drinks per day Greater than 2 drinks per day or stopped recently \_\_\_\_\_\_\_\_\_\_\_\_

Soda: None Less than 2 drinks per day Greater than 2 drinks per day or stopped recently \_\_\_\_\_\_\_\_\_\_\_\_

Sweets / Refined Carbs: None Less than 2 per day Greater than 2 per day

Sleep: Difficulty falling asleep\_\_\_ Continuity disturbances \_\_\_ Early morning awakenings \_\_Daytime drowsiness\_\_\_

Smoking: Yes No Packs daily \_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interested in stopping? \_\_\_\_\_\_\_\_

Stress Levels (1 = Low, 10 = Extreme): 1 2 3 4 5 6 7 8 9 10

How Do You Rate Your Stress Handling (1 = Low, 10 = Extreme): 1 2 3 4 5 6 7 8 9 10

Exercise routine: Never Rarely Sometimes Regularly Competitively

**MEDICATIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**DRUG ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SUPPLEMENTS TAKEN:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Ringing in Ear | Gall Bladder Trouble | Tremor/Hands Shaking | Earing Infections – Frequent |
| Jaundice/Hepatitis | Muscle Weakness | Dizziness/Fainting | Change in Bowel Habits |
| Numbness/Tingling Sensations | Failing Vision | Diarrhea | Constapation |
| Headaches – Frequent | Eye Infections | Diverticulosis | Crohns/Colitis |
| Arthritis / Rheumatism | Nose Bleeds | Bloody or Tarry Stools | Osteoporosis |
| Sinus Trouble | Hemorrhoids | Back Pain - Recurring | Sore Throats - Frequent |
| Hernia | Bone Fracture / Joint Injury | Hayfever/Allergies | Urine Infections - Frequent |
| Gout | Pneumonia | Blood in Urine | Foot Pain |
| Cold Numb Feet | Bronchitis / Chronic Cough | Urination - Frequent | Rashes |
| Hives | Asthma / Wheezing | Psoriasis | Eczema |
| Chest Pain | Nervousness | Depression | High Blood Pressure |
| Kidney Stones | Memory Loss | Heart Murmur | Venereal Disease |
| Moodiness - Excessive | Swollen Ankles | Urethral Discharge | Phobias |
| Leg Pain when Walking | Chronic Fatigue | Mentel Illness | Varicose Veins / Phlebitis |
| Weight Loss - Recent | Lactose Intolerance | Loss of Appetite | Anemia |
| Bruise Easily | Difficulty Swallowing | Cancer | Sexual / Menstrual Dysfunction |
| Indigestion or Heartburn | Diabetes | Frequent Infections | Persistent Nausea / Vomiting |
| Thyroid Disease | Diphtheria | Peptic Ulcers | Convulsions / Seizures |
| Tetanus | Abdominal Pain - Chronic | Stroke | Chicken Pox |
| Polio | Mumps | Measles | Rubella |
|  |  |  |  |

**FAMILY HISTORY**

**PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY**

|  |  |  |  |
| --- | --- | --- | --- |
| **Relationship** | **Age (if Living)** | **Age at Death** | **State of health or cause of death** |
|  |  |  |  |
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**HOSPITALIZATIONS**

|  |  |
| --- | --- |
| **Date** | **Reason** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP**

|  |  |
| --- | --- |
| Illness | **Relationship** |
| Diabetes |  |
| Cancer |  |
| Blood Disease |  |
| Glaucoma |  |
| Epilepsy |  |
| Rheumatoid Arthritis |  |
| Tuberculosis |  |
| Gout |  |
| High Blood Pressure |  |
| Heart Disease |  |
| Back Problems |  |

**INSTRUCTIONS: Check either “Ongoing” or “Just w/Period” for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity. Add any additional information in the appropriate column**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Signs & Symptoms** | **Ongoing** | **Just w/Period** | **Mild** | **Moderate** | **Severe** | **Additional Information** |
| Mood swings |  |  |  |  |  |  |
| Anxiety/Nervousness |  |  |  |  |  |  |
| Overly Reactive |  |  |  |  |  |  |
| Irritability |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |
| Lowered Self Esteem |  |  |  |  |  |  |
| Caretake others before yourself |  |  |  |  |  |  |
| Sadness/Crying |  |  |  |  |  |  |
| Foggy Thinking |  |  |  |  |  |  |
| Memory Difficulties |  |  |  |  |  |  |
| Fatigue |  |  |  |  |  |  |
| Constant Hunger |  |  |  |  |  |  |
| Sweet Cravings |  |  |  |  |  |  |
| Caffeine / Stimulant Cravings |  |  |  |  |  |  |
| Salt Cravings |  |  |  |  |  |  |
| Headaches/Migraines |  |  |  |  |  |  |
| Body/Joint/Back Aches |  |  |  |  |  |  |
| Weight Gain |  |  |  |  |  |  |
| Weight Loss |  |  |  |  |  |  |
| Water Retention |  |  |  |  |  |  |
| Bloating |  |  |  |  |  |  |
| Irritable Bowel |  |  |  |  |  |  |
| Constipation |  |  |  |  |  |  |
| Light Colored Stool |  |  |  |  |  |  |
| Loose Stool/Diarrhea |  |  |  |  |  |  |
| Nausea/Vomiting |  |  |  |  |  |  |
| Acne |  |  |  |  |  |  |
| Excessive Facial Hair |  |  |  |  |  |  |
| Body/Head Hair Loss |  |  |  |  |  |  |
| Dry skin/Brown Spots |  |  |  |  |  |  |
| Lowered Libido |  |  |  |  |  |  |
| Heightened Libido |  |  |  |  |  |  |
| Hot Flashes |  |  |  |  |  |  |
| Night Sweats |  |  |  |  |  |  |
| Breast Tenderness |  |  |  |  |  |  |
| Nipple Discharge |  |  |  |  |  |  |
| Vaginal Infections |  |  |  |  |  |  |
| Urinary Frequency |  |  |  |  |  |  |
| Incontinence |  |  |  |  |  |  |
| Vaginal Dryness |  |  |  |  |  |  |
| Painful Intercourse |  |  |  |  |  |  |

**REPRODUCTIVE HEALTH HISTORY** *(please fill in or circle the appropriate answer):*

1. Age at onset of menses (first period): \_\_\_\_\_\_\_\_\_\_\_\_ Approximate date of onset: \_\_\_\_\_\_\_\_\_\_\_
2. Are you currently using a method of birth control? Yes No Method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Are you or have you used (please circle) oral, injected, patch, or ring hormone contraceptives or used emergency contraception (the day after pill? Yes No
4. Are you or have you used an IUD? Yes No If using, when and for how long? \_\_\_\_\_\_\_\_\_\_\_\_
5. What type of IUD did you use? Copper Hormone Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy bleeding, weight gain, mood, acne, cravings, depression, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Have you used or are you currently using fertility or treatment? Yes No If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Have you used or are you currently using bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen)? Yes No If yes, what hormone dosage and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Have you been pregnant before? Yes No Age(s) of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. Please complete number of pregnancies per category:

|  |  |  |
| --- | --- | --- |
| **Pregnancy Category** | **Number** | **Details/Complications?** |
| Live Births |  |  |
| Miscarriages |  |  |
| Premature Births |  |  |
| Cesarean Births |  |  |
| Stillbirths |  |  |
| Abortions |  |  |
| Ectopic |  |  |

1. If you had a miscarriage, how many weeks pregnant were you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you had an abnormal Pap test? Yes No Reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal Pap test treatment or medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had a vaginal infection? Yes No If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaginal infection treatment or medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any history of…. Ovarian Cysts Yes No Uterine Fibroids? Yes No

Polycystic ovarian syndrome (PCOS) Yes No Endometriosis? Yes No

**FOR CYCLING-AGE WOMEN** *(please fill in or circle the appropriate answer)***:**

1. First day of last menstrual period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had a tubal ligation? Yes No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No

If yes, please give details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many days is your current cycle? (count from the first day of your period to the first day of your next period) <20 days 20-30 days 30-40 days 40-50 days > 50 days
2. How many days does menstruation typically last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is your menstrual cycle regular? Yes No Not Always Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Typical menstrual flow: Light Medium Heavy Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. How many pads and/or tampons (circle) are used on heavy days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Do you pass clots? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you spot? Yes No At what point in your cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Do you experience cramping? None Mild Moderate Severe

At what point in your cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you experience abnormal vaginal discharge? Yes No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you experience vaginal itching and/or odor? Yes No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you experience breast tenderness? None Mild Moderate Severe

At what point in your cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you experience nipple discharge? Yes No If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Color? \_\_\_\_\_\_\_

**FOR MENOPAUSAL WOMEN** *(please fill in or circle the appropriate answer):*

1. Your age at the onset of menopause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of onset: \_\_\_\_\_\_\_\_\_
2. Have you had a hysterectomy? (circle) Complete (ovaries AND uterus) Partial (uterus only)
3. Date of Hysterectomy: \_\_\_\_\_\_\_\_\_\_\_\_ Reason For: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. List any other GYN-related surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Describe your experience transitioning into menopause (symptoms, strong emotions, thoughts)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you used, or are you currently using conventional hormone replacement therapy? Yes No

If yes, what were you prescribed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What dosage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For How Long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you used, or are you currently using bioidentical hormone creams/gels/troche? Yes No

If yes, what were you prescribed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What dosage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For How Long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No

If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What dosage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For How Long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Were you evaluated and/or treated by a GYN? Yes No

Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE DESCRIBE YOUR CYCLE HISTORY**

1. How would you have described your menstruation?

Easy Uncomfortable Difficult Debilitating

1. What was your typical menstrual flow? Light Medium Heavy
2. When you were cycling, would you consider your cycle regular? Yes No

If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please describe any “treatment” ever received for cycle issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SLEEP HABITS**

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. How many hours do you sleep a night on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do night sweats wake you up? Yes No How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you wake up tired? Yes No How long has this been happening? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Is your room completely dark when you sleep at night (no night light, street lamp, TV)? Yes No
5. Do you get at least 30 minutes of outside daylight several days each week? Yes No