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Date of Consult:

# WOMEN'S HEALTH QUESTIONNAIRE

This questionnaire is intended to help you organize your thoughts in preparation of your appointment. Working together we can develop a plan to support your health and mental health, encouraging wellness. If you feel uncomfortable answering any of the questions on this form you may wait and discuss them with me.

## Section 1 PERSONAL INFORMATION

Name: Age:

Referred by/Phone #:

Primary healthcare provider/phone #:

Ethnic/cultural background (please check all that apply to you)
☐ Caucasian ☐ Black ☐ Asian ☐ Native American ☐ Biracial ☐ Hispanic/Latino

☐ Other (please Specify):

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Committed Relationship ☐ Other

Person/relationship to be called in emergency: Phone #:

Employment Status: ☐ Unemployed ☐ Employed ☐ Leave of Absence ☐ Retired ☐ Disabled ☐ F/T Student

If employed, occupation: Employer

## Section 2 WOMEN'S HEALTH ASSESSMENT

What are your main concerns or questions you would like addressed during your consultation:

1.

2.

3.

## Section 3 HEIGHT AND WEIGHT INFORMATION

What is your current height: What is your current weight: What is your ideal weight:

## Section 4 ALLERGY INFORMATION

Are you allergic to any medications? ☐ Yes ☐ No ☐ Don't know

If yes, please indicate which one(s) and reactions: (Use back of page if necessary)

Do you have any other allergies? ☐ Yes ☐ No ☐ Don't know If yes, please indicate:

**Section 5 MEDICAL HISTORY-** Please put a **C** (current) or **P** (past) to the **LEFT** of the item for symptoms/conditions you currently have/have had in the past:

| | | | | | |
|---|---|---|---|---|---|
| | Migraines/headaches | | Uterine Fibroids | | Hair loss |
| | High/ Low Blood Pressure | | Liver disease | | Hair growth |
| | Stroke | | Muscle or joint pain | | Weight loss |
| | High Cholesterol | | Back pain | | Weight gain |
| | Heart Attack | | Seizures | | Depression |
| | Chest Pain | | Sleeping problems | | Anxiety/Agitation |
| | Anemia | | Fatigue | | Panic attacks |
| | Colitis/IBS | | Eyesight issues | | Mood swings |
| | Diarrhea/constipation | | Cataracts/ Macular degeneration | | Suicidal thoughts |
| | Frequent nausea/vomiting | | Thyroid issues | | Irritability/Anger |
| | Black/bloody stool | | Dizziness/Vertigo/Tinnitus | | Trouble concentrating |
| | Incontinence (Urine or Stool) | | Teeth or Gum disease | | ADD/ADHD |
| | Gall bladder | | Skin disorders | | Other |
| | Hepatitis – A, B, C | | Frequent falling | | |
| | Breast Lumps/Cancer | | Losing height | | |
| | Endometriosis | | Broken bones | | |

**Section 6 MAJOR ILLNESS AND INJURY HISTORY**

List date of all operations, hospitalization, major injuries, and illnesses (excluding pregnancy):

SURGERIES/HOSPITALIZATIONS

| Year | Reason |
|---|---|
| | |
| | |
| | |

MAJOR INJURIES OR ILLNESSES

| Year | Reason |
|---|---|
| | |
| | |
| | |

**Section 7 EDUCATION**

Highest level completed ___HS diploma ____Some college____BA/BS____Graduate degree____Professional degree

Special issues/concerns/problems regarding your education?

______________________________________________________________________

______________________________________________________________________

## Section 8 FAMILY HISTORY

| Relative | Current Age | Age of Death/ Cause of Death | Current Health | Mental Health Issues |
|---|---|---|---|---|
| Mother | | | | |
| Father | | | | |
| Sister/s | | | | |
| Brother/s | | | | |
| Step Sister/Brothers | | | | |
| Half Sister/Brothers | | | | |
| Adopted Sister/Brothers | | | | |

Were you adopted? ____________ If so, do you know medical history about your biological parents?

_______________________________________________________________________________________

Please list family members who currently have/had in the past any of the following: use the following abbreviations: mother (M), father (F), sister (S), brother (B), maternal (MAT), paternal (P), Grandmother (GM), Grandfather (GF), aunt (A), uncle (U):

| | | | |
|---|---|---|---|
| High Blood Pressure: | Glaucoma: | Ovarian Cancer: | Domestic Violence: |
| Heart Attack/ Age: | Macular Degeneration: | Other Cancer: | Dementia or Alzheimer's Disease: |
| Stroke/Age: | Osteoporosis: | Depression: | Sexual Abuse: |
| Blood Clots: | Hip Fracture: | Bipolar/Manic Depression: | Other: |
| Bleeding Tendency: | Breast Cancer: | Alcohol Abuse: | |
| Diabetes: | Colorectal Cancer: | Substance Abuse: | |

Is there anything about your family's health history that concerns you, or that you would like to discuss? ☐ Yes ☐ No

If yes, what_______________________________________________________________________________

_______________________________________________________________________________________

## Section 9 MEDICATION (CURRENT)

Please indicate the medication and supplements you are currently using. Include prescription drugs and those purchased without a prescription, such as nutritional supplements (use back of page if necessary)

| MEDICATION | DOSE | FREQUENCY | DATE STARTED | DATE STOPPED | WHY STOPPED |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Section 10 GYNECOLOGIC HISTORY

How would you describe your current menstrual status?

☐ Premenopause (before menopause; having regular periods)

☐ Perimenopause/menopause transition (changes in periods but have not gone 12 months in a row without a period)

☐ Postmenopause (after menopause; no period for 12 months in a row)

Was your menopause:
- ☐ Spontaneous ("natural")
- ☐ Surgical (removal of both ovaries)
- ☐ Due to chemotherapy or radiation therapy; reason for therapy:________________________________
- ☐ Other (explain):________________________________________________________________

Are you currently using hormone therapy for menopause? ☐ Yes ☐ No If yes, which ones & for what *reason*

| | | | |
|---|---|---|---|
| Age at first menstrual period: | | | |
| Are your periods (or were your periods) usually regular? | | | |
| Do you have a uterus? | ☐ Yes | ☐ No | ☐ Don't Know |
| Do you have a cervix? | ☐ Yes | ☐ No | ☐ Don't Know |
| Do you have both ovaries? | ☐ Yes | ☐ No | ☐ Don't Know |
| If not still having periods, what was your age when you had your last period? | | | |
| If having periods or when you were, how often do they occur? | | | |
| How many days did /does your period last? | | | |
| Describe your current bleeding pattern ☐ None ☐ Light ☐ Medium ☐ Heavy | | | |
| Are your periods painful? ☐ Yes ☐ No If yes, how painful ☐ Mild ☐ Moderate ☐ Severe | | | |
| Do you spot or bleed between periods? | ☐ Yes | ☐ No | |
| Has there been a recent change in how often you have periods? | ☐ Yes | ☐ No | |

Has there been a recent change in how many days you bleed? ☐ Yes ☐ No

Has your period recently become heavy? ☐ Yes ☐ No

Do/did you have symptoms of PMS? (anxiety/agitation, irritability/anger, mood swings, depression, bloating, headache, etc. before your period)

______________________________________________________________________________

Do you examine your breast (Self breast exam SBE)?
If yes, how often?

What are the dates and results (if known) of the following tests? Please attach copies if available.

Pap smear: Any abnormal Pap test? ☐ Yes ☐ No If yes, When?

Mammogram: Any breast biopsies? ☐ Yes ☐ No If yes, When??

Blood sugar test: Bone density test: Thyroid / TSH:

Liver function test: Complete blood count (CBC):

## Section 11 OBSTETRICAL HISTORY

Please indicate the method of birth control, if any, that you are currently using (C ) or have used (P) in past:

| | | |
|---|---|---|
| None | Sterilization (tubes tied) When? | Male Partner had vasectomy |
| Birth Control pill, ring, skin patch | IUD | Injectable hormone (ie Depo-provera) |
| Implanted hormone (ie estrogen, Norplant, etc) | Barrier method: (Diaphragm Foam/Gel Condoms ) | |
| Natural family planning/rhythm | | |

How many times have you been pregnant? _______

Please provide the number of your:
Full term births Premature births Miscarriages Abortions Living children

Do you have any plans to become pregnant in the future? ☐ Yes ☐ No

How many children do you have: How many are adopted:
Ages and Gender?

Your age at time of birth of 1st child: Last child:

Any complications during pregnancy, delivery, or postpartum? If yes, please explain

Any depression, anxiety or other mental health problems during pregnancy, delivery or postpartum? If yes, please explain

## Section 12 PERSONAL HABITS

Do you consider your health to be: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

### EXERCISE

How often do you exercise? ☐ At least three times a week ☐ Occasionally ☐ Rarely ☐ Never

What activities and for how long?

Would you like exercise to be a bigger part of your life? ☐ Yes ☐ No ☐ Not sure

### SLEEP

Do you have problems sleeping on a regular basis? ☐ Yes ☐ No At what age did this begin?

How many hours do you sleep on an average? Do you wake up feeling rested? ☐ Yes ☐ No

Has your bed partner told you that you have: jumpy/jerking leg movements? ☐ Yes ☐ No

Do you have times while sleeping when you stop breathing or gasp for breath? ☐ Yes ☐ No

Did you have night terrors or sleep walking as a child? ☐ Yes ☐ No

Are you bothered by frequent nightmares? ☐ Yes ☐ No

**SLEEP** (continued)

| Do you or have you taken sleep aides to help you sleep? ☐ Yes ☐ No |
|---|
| If so, what are their names: |
| Over the counter |
| Prescription |
| Nutriceuticals (ie melatonin, valerian) |

**DIET**

| How many meals do you consume each day? Snacks? |
|---|
| Do you try to eat a low-fat diet? ☐ Yes ☐ No A diet low in simple carbohydrates? ☐ Yes ☐ No |
| Are you on a special diet? ☐ Yes ☐ No Have you ever had an eating disorder? ☐ Yes ☐ No<br>Describe your food intake for a typical day (use back of page if necessary) |

**TOBACCO USE**

| Do you smoke cigarettes? ☐ No ☐ Yes Are you interested in stopping smoking? ☐ Yes ☐ No<br>If you do not currently smoke cigarettes, have you ever smoked? ☐ Yes ☐ No |
|---|
| If yes, When did you start? How many per day? When did you stop? |
| Do you use any other type of tobacco? ☐ Yes ☐ No If yes, what?_ |

**CAFFEINE USE**

| Do you consume drinks with caffeine (coffee, tea, soda drinks)? ☐ Yes ☐ No |
|---|
| If yes, how many drinks each day? Why do you consume caffeine? |
| Do you consume caffeine from other sources (chocolate, herbal supplements, OTC medication, pills)? ☐ Yes ☐ No |
| If yes, in what form & how much each day |

**ALCOHOL AND DRUG USE**

| Do you drink alcohol ☐ Yes ☐ No<br>If yes, how many drinks do you have each week? What do you drink? |
|---|
| Do you ever have a drink in the morning to help you get going? ☐ Yes ☐ No |
| Have you ever tried to cut down on your drinking? ☐ Yes ☐ No |
| Have you ever felt guilty about the amount you drink? ☐ Yes ☐ No |
| How many times in the past year have you had four (4) or more drinks in a day?<br>None ☐ 1 - 2 ☐ 3 - 5 ☐ 6 – 12 ☐ More than 12 ☐ |
| Do you use recreational drugs? ☐ Yes ☐ No<br>If yes, which ones:<br>Do you use medical marijuana ☐ Yes ☐ No |

## Section 13 SEXUAL HISTORY

Are you sexually active? ☐ Yes ☐ No

If yes, are you currently having sex with: ☐ A man (or men) ☐ A women (or women) ☐ Both men and women

How long have you been with your current sex partner? ______________________

Are you in a committed, mutually monogamous relationship? ☐ yes ☐ No

Do you have concerns about your sex life? ☐ yes ☐ No

Do you have a loss of interest in sexual activities (libido, desire)? ☐ yes ☐ No

Do you have a loss of arousal (tingling in genitals, breasts;
Vaginal moisture, warmth)? ☐ Yes ☐ No

Do you have a loss of response (weaker or absent orgasm)? ☐ Yes ☐ No

Do you have pain with intercourse (vaginal penetration)? ☐ Yes ☐ No

If yes, how long ago did it the pain start?

Do you have any questions about your sexual health? ☐ Yes ☐ No

## Section 14 ABUSE/TRAUMA Physical/ Sexual/Emotional

Have you been hit, slapped, kicked, or otherwise physically hurt by someone? ☐ Yes ☐ No

Has anyone ever forced you to have sex? ☐ Yes ☐ No

☐Within last year ☐ Ever

Do you feel you have been verbally or emotionally abused by someone? ☐ Yes ☐ No

## Section 15 STRESS MANAGEMENT/SOCIAL SUPPORT (use back of page if necessary)

What are the current major stressors or life changes in your life:

Any major losses or changes in your health or family health during the past year? ☐ Yes ☐ No
If yes, explain

How do you handle stress? ☐ Very Well ☐ Moderately well ☐ Poorly

What is your response to stress?

What do you do to relax?

What are your hobbies?

Describe your support system

Do you have a best friend/s ☐ Yes ☐ No

**Section 16 MENTAL HEALTH**

During the past two weeks, have you often felt down, depressed, hopeless? ☐ Yes ☐ No

During the past two weeks, have you had little interest or pleasure in doing things you usually find pleasurable? ☐ Yes ☐ No

Do your experience significant mood swings? ☐ Yes ☐ No

How do your current symptoms interfere with your life?

How would you rate your quality of life? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you ever been prescribed psychiatric medications? ☐ Yes ☐ No If yes, by whom:

Name/s Dates

| If so, name of medication | Dosage | When started/stopped | Benefits | Side Effects |
|---|---|---|---|---|
| | | | | |
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| | | | | |

Have you ever seen a counselor/therapist? ☐ Yes ☐ No

Name/s Date/s

Have you ever been hospitalized in a psychiatric hospital? ☐ Yes ☐ No

If so, where and when

Would you like referrals for mental health care today? ☐ Yes ☐ No

**Section 17 RELIGION/SPIRITUALITY**

Were you raised in a religious family? ☐ Yes ☐ No If yes, what religion?

Do you have a specific religion or spiritual path that is an important part of your current life? ☐ Yes ☐ No

Do you wish that religion/spirituality was a bigger part of your current life? ☐ Yes ☐ No

**Section 18** **MENOPAUSE SYMPTOMS LIST**
Please indicate how bothered you are now and in the past 3 months by any of the following:

| **Symptom** | **Not at all** | **A little bit** | **Quite a bit** | **Extremely** |
|---|---|---|---|---|
| I have hot flashes | | | | |
| I have night sweats | | | | |
| I have difficulty getting to sleep | | | | |
| I have difficulty staying asleep | | | | |
| I wake two hours earlier than I want in the morning | | | | |
| I get heart palpitations or a sensation of butterflies in my chest or stomach | | | | |
| My skin feels crawling; dry, itching | | | | |
| I feel more tired than usual | | | | |
| I have difficulty concentrating | | | | |
| My memory is poor: Short term/Long term | | | | |
| I am more irritable than usual | | | | |
| I have more depressed moods | | | | |
| I have crying spells | | | | |
| I have headaches | | | | |
| I have frequent/recurrent bladder infections or leakage | | | | |
| I have frequent diarrhea, constipation or bloating | | | | |
| My vagina is dry / I have trouble with lubrication | | | | |
| I have vulvar / vaginal itching/burning/pain | | | | |
| I have abnormal vaginal discharge/frequent infections | | | | |
| I have pain druing intercourse | | | | |
| I have bleeding after intercourse | | | | |
| I have breast or nipple tenderness/pain | | | | |
| I have muscle or joint pains | | | | |
| I have other types of pain/describe | | | | |
| Other Symptoms | | | | |

**Section 19** **ABOUT MENOPAUSE AND HORMONE THERAPY**

How do you view menopause?

☐ Positively. Menopause means no more periods and no more worry about contraception. Menopause marks a new life phase. Other_______________________________________________

☐ Negatively. Menopause means a loss of fertility and loss of youth. Other__________________________________

☐ Other_____________________________________________________________________________

What concerns do you have about menopause or hormone therapy for peri/menopause?

What are your current views regarding hormone therapy of menopause?

☐ Positive. Hormone therapy is appropriate for some women.

☐ Negative. I don't support the use of hormone therapy.

How would you rate your knowledge about menopause?

☐ Very Good ☐ Fair ☐ Moderately Good ☐ Little knowledge

How do you get your information about menopause? (mark all that apply)

☐ Books ☐ Internet ☐ Magazines ☐ Friends ☐ TV ☐ Healthcare providers

Is there anything else you would like me or your healthcare provider to know?

Thank you!
Please note that the information you have provided will be held in the strictest confidence except in the following situations: you sign a release of information, you ask for a receipt to submit to your insurance carrier, in reponse to a subpoena or by California State law.