



Feminine Health Questionnaire

Personal

Name: _____ Age: _____ Today's date: _____
 Date of last regular menstrual cycle: _____ Length of cycle: _____
 Form of Birth Control: _____ No. Children: _____ Miscarriages: _____ Still births: _____
 C-Section: _____ Surgical menopause? _____ Please describe: _____
 Date of last Pap: _____ Date of last mammogram: _____
 On a scale of 1-10, what is your stress level? _____ Identify the major cause: _____

Medical History

Are you now or have been in the past on hormone replacement therapy? _____
 Have experienced unintentional weight loss or gain of 10 pounds or more in the past 3 months? _____
 Do you diet frequently? _____ Skip a meal? _____ How many meals do you eat per day? _____
 Salt? _____ Fiber? _____ Animal protein? _____ Dairy products? _____

Check all the symptoms you experience regularly one to two weeks before your period

<input type="checkbox"/> Abdominal bloating	<input type="checkbox"/> Confused	<input type="checkbox"/> Craving	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart	<input type="checkbox"/> Shakes	<input type="checkbox"/> Tender
<input type="checkbox"/> Aggressive or hostile towards family/friends	for sweets	<input type="checkbox"/> Depression	<input type="checkbox"/> palpitations	<input type="checkbox"/> Increased appetite	<input type="checkbox"/> swollen breast	<input type="checkbox"/> Water retention
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Forgetful	<input type="checkbox"/> insomnia	<input type="checkbox"/> Irritability	<input type="checkbox"/> weight gain	<input type="checkbox"/> Withdrawn
<input type="checkbox"/> Breast pain						

Other: _____

Check all the symptoms and/or behaviors that occur during your period with a frequency that affects your daily activities:

<input type="checkbox"/> Accident prone	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability	<input type="checkbox"/> Sharp intermittent pain
<input type="checkbox"/> Breast pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Low back pain	<input type="checkbox"/> Tender swollen breast
<input type="checkbox"/> Cramping in lower abdomen or pelvic area	<input type="checkbox"/> Difficulty concentrating	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Unusual Fatigue
<input type="checkbox"/> Decreased productivity	<input type="checkbox"/> Dull aching pain	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Upset stomach
	<input type="checkbox"/> Headaches	<input type="checkbox"/> Painful intercourse	<input type="checkbox"/> Weight gain

Other: _____



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Check any of the following statements that describe your menstrual cycle energy level or reproductive function:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abnormal vaginal discharge | <input type="checkbox"/> Frequent menstruation (21-24 days) | <input type="checkbox"/> Menstrual bleeding lasts longer than 5 days | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Absence of periods for 3 months or more | <input type="checkbox"/> Frequently skip periods | <input type="checkbox"/> Menstruations last three days and are light | <input type="checkbox"/> chronic fatigue |
| <input type="checkbox"/> Bleeding or spotting between periods | <input type="checkbox"/> Irregular periods (once every 3-6 months) | <input type="checkbox"/> Unusually light or heavy periods | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Bleeding between periods is light (staining) | <input type="checkbox"/> Heavy prolonged menstrual bleeding | <input type="checkbox"/> Unusually light menstrual bleeding (spotting) | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Bleeding between menstruation is heavy | <input type="checkbox"/> Menstrual cycle every 36 days or longer | <input type="checkbox"/> Vaginal itching, burning, or dryness | <input type="checkbox"/> Memory problem |
| | | | <input type="checkbox"/> Shortness of breath |
| | | | <input type="checkbox"/> Headaches |
| | | | <input type="checkbox"/> Bone pain |

Other: _____

Check any of the following symptoms if they occur throughout the month with an intensity or frequency that affects your ability to perform your daily activities or feel good about yourself:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Bleeding between periods | <input type="checkbox"/> Difficulty with orgasm | <input type="checkbox"/> Irritability | <input type="checkbox"/> Spontaneous sweating |
| <input type="checkbox"/> Change in sexual desire | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Joint and muscle pain | <input type="checkbox"/> Stopped menstruating |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Forgetful | <input type="checkbox"/> Loss of muscle tone | <input type="checkbox"/> Urinary problem |
| <input type="checkbox"/> Decline of vital energy and sense of well being | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Vaginal problems |

Other: _____

NOTES:
