

FOR WOMEN ONLY: Confidential History

Name _____ Date _____

Age _____ Birth Date _____ Height _____ Weight _____ Date of last physical examination _____

What are your main health concerns? _____

MENSTRUAL & GYNECOLOGICAL SYMPTOM REVIEW

How old were you when you had your first period start? _____ Did you have any problems then? _____

How was your period in your twenties? _____ Thirties? _____

How is your period now (if you still are menstruating)? _____

Do you have any PMS symptoms? If yes, what are they? _____

Do you have menopausal symptoms? _____

Are you experiencing mood changes with menopause? _____

Name of your gynecologist _____ Date of last Pap smear _____

Have you had a mammogram? And when? _____ A bone density study (DXA scan)? _____

Number of children _____ Are you pregnant now? _____ Attempting pregnancy? _____

Do you have fibroids? _____ Size _____ Date of last sonogram _____

Ovarian cysts? _____ Breast cancer? _____

Is your cholesterol high? _____ Other cardiovascular risk factors _____

Do you have osteoporosis or osteopenia? _____ Do you have any urinary tract complaints? _____

Do you have any vaginal complaints? _____ How is your libido? _____

Other complaints? _____

MEDICATION REVIEW

What medications do you currently take? _____

Are you using prescription hormones? _____

Do you use any natural hormone preparations? _____

What nutritional supplements do you take? _____

Have you had any adverse reactions to medications? _____