Full Name *

First Name

Last Name

Date *

MM-DD-YYYY

Date

How many times have you been pregnant? *

How many miscarriages have you had? *

Have you had any premature deliveries? *

Are you sexually active? *

Do you experience any pain with intercourse? *

Have you had a hysterectomy? *

If yes, please skip 7-16.

Do you have PMS symptom? *

If you no longer have periods, please state the reasons: *

First day of last period? *

MM-DD-YYYY

Date

How many days does your period last? *

Are your periods regular? *

How many days from the start of your period to the start of the next? *

Do you have any bleeding between periods? *

Do you have any cramping with your periods? *

What type of contraception are you currently using? *

- [ ] Pills
- [ ] Condoms
- [ ] Depo Provera
- [ ] Vasectomy
- [ ] Implants
- [ ] Tubal Ligation
- [ ] Withdrawl
- [ ] Foam
- [ ] Diaphragm
- [ ] Other

Are you having problems with your method of birth control? *

Date of last Pap smear? *

MM-DD-YYYY

Date

Have you ever had an abnormal Pap smear? *

Have you ever trouble with leaking urine? *

Do you have breast lumps, tenderness, or discharge? *

Have you had a mammogram? If yes, was it normal? *

Date of last mammogram *

MM-DD-YYYY

Date

Do you have hot flashes or menopause symptoms? *

Do you have uterine abnormities? If yes, are they Mild, Moderate or Severe? *

Do you smoke? *

If yes, # per day? For how many years? *

Do you or any family member have a history of heart attack, blood clots, or stroke? *

Do you or any family member have a history of breast cancer? *

Complaints and Concerns

What do you hope to achieve in your visit with us? _____
_____

Date of symptom or injury onset? _____
If you had a magic want and you could erase three problems, what would they be?

1. _____
2. _____
3. _____

Current Height: _____ Current weight: _____

Medical Symptoms Questionnaire (MSQ)

Rate each of the following symptoms based upon your typical health profile for the past 30 days:

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD _____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia Total _____

EYES _____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or drack circles under eyes
_____ Blurred or tunnel vision (does not include near or far-sightedness)
Total _____

EARS _____ Itchy ears
_____ Earaches, Ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss Total _____

NOSE _____ Stuffy noes
_____ Sinus problems
_____ Hay fever
_____ Sneezing
_____ Sneezing attacks
_____ Excessive mucus formation Total _____

MOUTH/THROAT

_____	Chronic coughing	
_____	Gagging, frequent need to clear throat	
_____	Sore throat, hoarseness, loss of voice	
_____	Swollen or discolored tongue, gyms. Lips	
_____	Canker sores	Total _____

SKIN _____	Acne	
_____	Hives, rashes, dry skin	
_____	Hair loss	
_____	Flushing, hot flashes	
_____	Excessive sweating	Total _____

HEART _____	Irregular or skipped heartbeat	
_____	Rapid or pounding heartbeat	
_____	Chest pain	Total _____

LUNGS _____	Chest congestion	
_____	Asthma, bronchitis	
_____	Shortness of breath	
_____	Difficulty breathing	Total _____

DIGESTIVE TRACT

_____	Nausea, vomiting	
_____	Diarrhea	
_____	Constipation	
_____	Bloated feeling	
_____	Belching, passing gas	
_____	Heartburn	
_____	Intestinal/stomach pain	Total _____

JOINTS/MUSCLE

_____	Pain or aches in joints	
_____	Arthritis	
_____	Stiffness or limitation of movement	
_____	Pain or aches in muscles	
_____	Feeling of weakness or tiredness	Total _____

Weight

_____	Binge eating/drinking	
_____	Craving certain foods	
_____	Excessive weight	
_____	Compulsive eating	
_____	Water retention	
_____	Underweight	Total _____

Energy/Activity

_____	Fatigue, sluggishness	
_____	Apathy, lethargy	
_____	Hyperactivity	
_____	Restlessness	Total _____

Mind

_____	Poor memory	
_____	Confusion, poor comprehension	
_____	Poor concentration	
_____	Poor physical coordination	
_____	Difficulty in making decisions	
_____	Stuttering or stammering	
_____	Slurred speech	
_____	Learning disabilities	Total _____

Emotions

_____	Mood swings	
_____	Anxiety, fear, nervousness	
_____	Anger, irritability, aggressiveness	
_____	Depression	Total _____

Other

_____	Frequent illness	
_____	Frequent or urgent urination	
_____	Genital itch or discharge	Total _____

Grand Total: _____

Additional Comments:

_____
_____
_____
_____
_____
_____

FEMALE HRT SYMPTOM QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

In the past 2 weeks, please indicate if you have had any of these symptoms and rate the symptoms from 1 to 5. 1 - not too much of a problem - 5 - very much a problem. Use the blank space to explain or comment.

Anxiety/irritability	1	2	3	4	5	N/A	
Tearful	1	2	3	4	5	N/A	
Sleep disturbance/insomnia	1	2	3	4	5	N/A	
Mood Swings	1	2	3	4	5	N/A	
Breakthrough Bleeding	1	2	3	4	5	N/A	
Decreased concentration	1	2	3	4	5	N/A	
Brain fog or Memory loss	1	2	3	4	5	N/A	
Feeling overwhelmed	1	2	3	4	5	N/A	
Night sweats/hot flashes	1	2	3	4	5	N/A	
Fatigue	1	2	3	4	5	N/A	
Vaginal dryness	1	2	3	4	5	N/A	
Breast tenderness	1	2	3	4	5	N/A	
Heavy Periods	1	2	3	4	5	N/A	
Depression Symptoms	1	2	3	4	5	N/A	
Urinary Incontinence	1	2	3	4	5	N/A	
Swelling in hands/feet	1	2	3	4	5	N/A	
Hot flashes during the day	1	2	3	4	5	N/A	
Muscle gain/loss	1	2	3	4	5	N/A	
Lack of Motivation	1	2	3	4	5	N/A	
Acne or Oily Skin	1	2	3	4	5	N/A	
Low Libido	1	2	3	4	5	N/A	
Poor recovery after workouts	1	2	3	4	5	N/A	
Craving Sweets or Salt	1	2	3	4	5	N/A	
Constipation or Diarrhea	1	2	3	4	5	N/A	
Hot/cold feet or hands	1	2	3	4	5	N/A	
Difficulty losing weight	1	2	3	4	5	N/A	
Hair Loss/thinning hair	1	2	3	4	5	N/A	
Pain during sex	1	2	3	4	5	N/A	