New Female Patient Questionnaire

Name:_____ DOB:_____ Age:_____

Height:_____ Weight:_____

Last Menstrual Period:_____ Last Pap:_____ Last Mammogram:_____

Contraceptive Use (choose method currently used):

Oral pills IUD Nexplanon Injections

Sterilization (ablation/tubal) Partial Hysterectomy Full Hysterectomy

Personal history of breast cancer? Yes No

Personal history of Polycystic Ovary Syndrome (PCOS)? Yes No

Family history of breast or prostate cancer? Yes No

Previous hormone replacement:_____

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Please mark which of the following symptoms you have experienced in the last two weeks on a scale of 0-5, where 0=none and 5=very severe/daily.

Physical exhaustion/ fatigue

0 1 2 3 4 5

Depressed mood

0 1 2 3 4 5

Anxiety

0 1 2 3 4 5

Irritability

0 1 2 3 4 5

Hot Flashes

0 1 2 3 4 5

Sweating (night sweats or sweating episodes)

0 1 2 3 4 5

Weight Gain/ Difficulty Losing Weight

0 1 2 3 4 5

Hair Loss/ Thinning Hair

0 1 2 3 4 5

Memory issues

0 1 2 3 4 5

Difficulty Concentrating/Thinking/Reasoning

0 1 2 3 4 5

Joint/Muscle Pain

0 1 2 3 4 5

Vaginal Pain (dryness/burning/painful intercourse)

0 1 2 3 4 5

Sexual Difficulties (change in desire/climax)

0 1 2 3 4 5

Sleep Problems

0 1 2 3 4 5

Dry Skin

0 1 2 3 4 5

Headaches

0 1 2 3 4 5

Bladder Issues (incontinence, urgency, frequency)

0 1 2 3 4 5

Breast Tenderness

0 1 2 3 4 5