SYMPTOM CHECKLIST

Please indicate how often you have the following:

Symptom			
Night Sweats	☐Frequently	☐Rarely	☐Never
Hot flashes/hot flushes	☐Frequently	☐Rarely	☐Never
Pain with intercourse	☐Frequently	☐Rarely	☐Never
Vaginal dryness	☐Frequently	☐Rarely	☐Never
Sleeping problems	☐Frequently	☐Rarely	☐Never
Urine leaks when you cough or sneeze	☐Frequently	☐Rarely	☐Never
Difficulty concentrating/memory loss	☐Frequently	☐Rarely	☐Never
Mood swings	☐Frequently	☐Rarely	☐Never
Migraines	☐Frequently	☐Rarely	☐Never
Depression	☐Frequently	☐Rarely	☐Never
Anxiety	☐Frequently	☐Rarely	☐Never
Decrease in sexual desire	☐Frequently	☐Rarely	☐Never
Decrease in energy level	☐Frequently	☐Rarely	☐Never
Loss of memory	☐Frequently	☐Rarely	☐Never
Foggy thinking	☐Frequently	☐Rarely	☐Never
Muscle and/or joint pain	☐Frequently	☐Rarely	☐Never

Please check the boxes below if they apply to how you have dealt with the above symptoms:

Herbal medications/supplements ☐YES ☐NO
Please specify how:____

Change of diet: ☐YES ☐NO
Please specify how:____

Layered clothing: ☐YES ☐NO
Please specify how:____

Increase exercise: ☐YES ☐NO
Please specify how:____

Other:____
____
____
____

Patient Name: ______________________DOB:__________ Clinic #:__________

GYN HISTORY

Are you sexually active? ☐YES ☐NO

Have you been sexually active? ☐YES ☐NO

Do you have pain with intercourse? ☐YES ☐NO

What types of contraception are you currently using? (Please check below all that apply)
☐Pills ☐IUD ☐Foam ☐Condoms
☐Tubal ligation ☐Vasectomy ☐Diaphragm ☐Withdrawal
☐Implants ☐Depo ☐Provera
☐Other:____

What type of contraception have you used in the past? (Please check below all that apply):
☐Pills ☐IUD ☐Foam ☐Condoms
☐Tubal ligation ☐Vasectomy ☐Diaphragm ☐Withdrawal
☐Implants ☐Depo ☐Provera
☐Other:____

Are you having any problems with your method of birth control: ☐YES ☐NO

Have you ever had any vaginal, cervical and/or tubal infection: ☐YES ☐NO

If yes, please check below call that apply:
☐Gardnerella ☐Syphillis ☐Condyloma ☐Bacterial Vaginitis ☐Yeast
☐PID ☐Herpes ☐Chlamydia ☐Gohorrhea ☐Warts
☐Other:____

Date of last pap smear:______________________________

Have you ever had an abnormal pap smear? ☐YES ☐NO

If yes, how was it treated (please check below all that apply):
☐Repeated Pap Smear ☐Colposcopy ☐Laser Surgery ☐Cone Biopsy
☐Cryosurgery (freezing) ☐Hysterectomy ☐Loop Excision

Have you ever had cervical cancer? ☐YES ☐NO
If yes, how was it treated?____

Have you ever had uterine cancer? ☐YES ☐NO
If yes, how was it treated?____

Have you ever had ovarian cancer? ☐YES ☐NO
If yes, how was it treated?____

Do you have trouble leaking urine? ☐YES ☐NO

Do you have any breast lumps, tenderness or discharge? ☐YES ☐NO

Have you ever had a mammogram? ☐YES ☐NO
If yes, was it normal? ☐YES ☐NO
Date of last mammogram? ____

Do you do self breast exams? ☐YES ☐NO

Do you have PMS Syndrome? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO
If yes, what type of treatment?____

Do you have any uterine abnormality? ☐YES ☐NO

Do you have a history of infertility? ☐YES ☐NO

Patient Name: ______________________________DOB:______________ Clinic #:______________

Do you have a history of DES exposure? ☐YES ☐NO

Do you have fibroids of the uterus? ☐YES ☐NO

Have you had abnormal bleeding in the past year? ☐YES ☐NO
If yes, please describe:______________________________

At what age did you start menopause?______________________

MENSTRUAL HISTORY

If you no longer have periods, please check the reason: ☐Natural ☐Hysterectomy ☐Ablation ☐Menopause

Do you have a uterus? ☐YES ☐NO

First day of last period:____________________

Typically, how many days do your periods last?____________________

Are your periods regular? ☐YES ☐NO

How many days are between the start of your periods?____________________

Has the flow of your periods changed in any way? ☐YES ☐NO
If yes, please explain the change:______________________________

Does bleeding occur between your normal period cycle? ☐YES ☐NO

Do you suffer from cramps during your periods? ☐YES ☐NO
If yes, please check the pain associated with the cramps:
☐MILD ☐MODERATE ☐SEVERE

What medicine, if any, are you currently taking for your cramps?______________________________
____

SMOKING HISTORY

Do you smoke cigarettes? ☐YES ☐NO
If yes, how many do you smoke per day on average?____________________
How many years have you been smoking?____________________

Do you use recreational drugs? ☐YES ☐NO

Do you drink alcohol ☐YES ☐NO
If yes, what type of alcohol do you drink?______________________________
How many drinks per week do you drink on average?____________________

Are you using any form of Testosterone therapy? ☐YES ☐NO
If yes, please check which type:
☐Gel ☐Cream ☐Shots ☐Pellets ☐Other

Patient Name: ______________________________DOB:____________ Clinic #:____________

MEDICAL HISTORY

Do you have diabetes? ☐YES ☐NO
Do you have or have you ever had hypertension? ☐YES ☐NO
Do you have heart disease? ☐YES ☐NO
Have you ever had a heart attack? ☐YES ☐NO
Have you ever had a stroke? ☐YES ☐NO
Do you have a heart murmur? ☐YES ☐NO
Do you have or have you ever had kidney disease? ☐YES ☐NO
Have you ever been treated for a psychiatric disorder? ☐YES ☐NO
If yes, name the disorder:____
Have you ever had rheumatic fever? ☐YES ☐NO
Do you have mitral valve prolapse? ☐YES ☐NO
Have you ever had a urinary tract infection? ☐YES ☐NO

Have you ever had hepatitis? ☐YES ☐NO
If yes, please check which type::
☐Hepatitis A ☐Hepatitis B ☐Hepatitis C ☐Other______________________

Have you ever had liver disease? ☐YES ☐NO

Have you ever had varicose veins? ☐YES ☐NO

Have you ever had phlebitis? ☐YES ☐NO

Do you have any thyroid problems? ☐YES ☐NO
If yes, please check the problem:
☐Low Function ☐Overactive ☐Goiter ☐Hashimoto's

Have you ever had a blood transfusion? ☐YES ☐NO

Do you have asthma, emphysema or chronic bronchitis? ☐YES ☐NO

Do you have or have you ever had leukemia? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO
Please check the type of treatment: ☐SURGERY ☐RADIATION

Do you have or have you ever had lymphoma? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO
Please check the type of treatment? ☐SURGERY ☐RADIATION

Do you have or have you ever had colon cancer? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO
Please check the type of treatment? ☐SURGERY ☐RADIATION

Do you have or have you ever had colon polyps? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO

Do you have or have you ever had multiple myeloma? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO

Do you have or have you ever had lung cancer? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO

Do you have or have you ever had rectal cancer? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO
Please check the type of treatment: ☐SURGERY ☐RADIATION

Patient Name: ________________________________DOB:_______________ Clinic #:_______________

Do you have or have you ever had breast cancer? ☐YES ☐NO
If yes, are you currently undergoing treatment? ☐YES ☐NO
Please check the type of treatment:
☐Lumpectomy ☐Mastectomy ☐Radiation ☐Chemotherapy

Do you have any drug allergies? ☐YES ☐NO
If yes, please list the drugs you are allergic to:______________________________

Please list all major surgeries (including year and reason):______________________________

Please list any other operations/hospitalizations (including year and reason):______________________________

Have you ever had any anesthesia complications? ☐YES ☐NO
If yes, please explain:______________________________

Are you currently or have you ever been anemic? ☐YES ☐NO

Do you have an internist or Family Physician? ☐YES ☐NO

Please list the name of the physician and a number where they may be reached:
Physician name:______________________ Phone number:______________

Are you currently taking any medications? ☐YES ☐NO
If yes, please list each medication and dosage:______________________________

Have you ever had your cholesterol checked? ☐YES ☐NO
If yes, when was it last checked?______________________________
How was your cholesterol? ☐LOW ☐NORMAL ☐HIGH

Do you have arthritis? ☐YES ☐NO
If yes, what type?______________________________

Do you have lupus? ☐YES ☐NO

Do you have scleroderma? ☐YES ☐NO

Do you have rheumatoid arthritis? ☐YES ☐NO

Have you had blood clots in your legs or lungs? ☐YES ☐NO

Do you have a problem with water retention? ☐YES ☐NO

Do you have problems with swelling? ☐YES ☐NO

Do you have problems with bloating? ☐YES ☐NO

Do you have osteopenia? ☐YES ☐NO
If yes, how was it treated?______________________________

Do you have osteoporosis? ☐YES ☐NO
If yes, how was it treated?______________________________

Patient Name: ______________________ DOB:______________ Clinic #:______________

Do you suffer from hair loss? ☐YES ☐NO

Do you suffer from or have you had acne? ☐YES ☐NO

FAMILY HISTORY

Do you have a family history of breast cancer? ☐YES ☐NO
If yes, with who is your family history?______________________________

Do you have a family history of colon cancer? ☐YES ☐NO
If yes, with who is your family history?______________________________

Do you have a family history of ovarian cancer? ☐YES ☐NO
If yes, with who is your family history?______________________________

Do you have a family history of osteoporosis? ☐YES ☐NO
If yes, with who is your family history?______________________________

Do you have a family history of diabetes? ☐YES ☐NO
If yes, with who is your family history?______________________________

Do you have a family history of hypertension? ☐YES ☐NO
If yes, with who is your family history?______________________________

Do you have a family history of heart disease? ☐YES ☐NO
If yes, with who is your family history?______________________________

Do you have a family history of kidney disease? ☐YES ☐NO
If yes, with who is your family history?______________________________
At what age did you mother go through menopause?______________________