Female Health History Questionnaire
(To be completed by the patient)

Name ____Date __________________
Date of Birth ____________________________ Age ___________
Weight __________ Height __________

Please describe your symptoms in detail (use other side if necessary):
____
____
____
____

Prescription Drug Usage

Please check if you use an of the following and then list exact names of any medications you are currently using:

□ Antacids, Zantac, Pepcid AC, Rolaids, etc.
□ Chemotherapy
□ Laxatives
□ Ulcer medications
□ Antibiotic / Antifungal
□ Anti-diabetic / Insulin
□ Oral contraceptives
□ Thyroid
0 Anti-depressants
0 Aspirin/acetaminophen
0 Heart Medications
0 Cortisone/Anti-inflammatory
0 High blood pressure medication
0 Statins/cholesterol lowering medications
0 Relaxants/Sleeping Pills
□ Hormones - If so, what? _______________________ When? _____________ Dosage?
____

Please list names of any medications you are currently taking - list dosage and length of time.
____
____
____

Please list anything that you **believe** you are allergic to or sensitive to:
____

____
____
What allergies or sensitivities have been **confirmed** by any type of testing?
____
____
____

How long have you had your symptoms? ____________________________________
Are your symptoms: **mild** **moderate** **severe**
Each year, are your symptoms getting : **better** **worse** **no change**

Supplement / Vitamin Usage - Please list any you are currently taking:
____
____
____
____

Surgeries, Accidents, Traumas -
Please list any surgeries, accidents or traumas you have had along with the dates.
____
____
____

Lifestyle

Dietary Habits -
Describe the foods you normally eat:
Breakfast
____
____
Lunch
____
____
Dinner
____
____
Snacks
____

Do you consume the following? If so, **how much**?
1. Soda or carbonated beverages ____ Yes ____ No ____________________________
2. White flour products ____ Yes ____ No ____________________________
3. Fried foods ____ Yes ____ No ____________________________
4. Coffee ____ Yes ____ No ____________________________
5. Fast foods regularly ____ Yes ____ No ____________________________
6. Sweets and / or refined carbohydrates ____ Yes ____ No
____

7. Alcoholic beverages ____ Yes ____ No ____________________________
8. Tobacco products ____ Yes ____ No ____________________________
Are you a vegetarian? ____ Yes ____ No
Are you currently involved in an exercise program? ____ Yes ____ No

How would you rate your stress level? (1 = Low, 10 = Extreme) 1 2 3 4 5 6 7 8 9 1 0
How do you rate your stress handling? (1 = Poor, 10 = Excellent) 1 2 3 4 5 6 7 8 9 1 0

Female Anatomy / Reproductive Health (to be completed by all women)

Age at onset of first period: _______ Approximate date of onset: ____

What are you using for contraception at the moment? ____

Have you ever used oral, injected, patch or ring contraceptives or used Emergency Contraception
("the day after" pill)? ____ Yes ____ No
From ___________________ to ____
Did you suffer from any side effects? ____ Yes ____ No Explain: ____

Are you currently or have you ever used an IUD? ____ Yes ____ No Name of IUD ____
When? __________________ For how long? ___________________________________
While under the use of any and all birth control methods, did you experience the following?
Yeast Heavy / Light Bleeding Mood Weight Gain Acne Sweet Cravings Fatigue Depression Palpitations, etc. (Please circle and use extra space provided if explanation is needed)
____
____

Are you currently, or have you ever used fertility treatment? ____ Yes ____ No
If yes, please explain:
____
____

Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc? ____ Yes ____ No
If yes, what hormone(s), dosage and for how long? Please be specific with dates of use.
____
____
Do you have any history of abnormal Pap Tests? ____ Yes ____ No
If yes, please explain:

____
Do you have any history of vaginal infections? ____ Yes ____ No
If yes, please describe:
____

Do you have any history of the following conditions? (Please circle appropriate answer)
Ovarian Cysts Fibrocystic Breasts Polycystic Ovarian Syndrome (PCOS) Uterine Fibroids Endometriosis Lichen Sclerosis Vuvodynia

Pregnancy History (to be completed by all women, if applicable)

Have you been pregnant before? ____ Yes ____ No
Please list the age(s) of your children:
____

Please explain important details / complications:
Number of pregnancies: ____
____
Number of live births: ____
____
Number of miscarriages: ____
____
How many weeks gestation at the time of miscarry? ____ Weeks
Number of premature births: ____
____
Number of cesarean births: ____
____
Number of stillbirths: ____
____
Number of ectopic pregnancies: ____
____

Cycling History (to be completed by all women who have not reached menopause)

What was the first date of your last menstrual period (LMP)?
____
Have you ever had tubal ligation surgery? ____ Yes ____ No
If so, please list the date and speci_c details:
____
____

Counting from the first day of your cycle to the first day of your next cycle, how many

days is your current cycle? (Please circle appropriate answer)

<20 days 20 - 30 days 30 - 40 days 40 - 50 days >50 days
What is the length of days your menstruation typically lasts? _____
Do you consider your cycle to be regular? ____ Yes ____ No ____ Not Always
Details:
____
What is your typical menstrual flow like? ____ Light ____ Medium ____ Heavy
How many pads and / or tampons (circle) do you use on heavy days? ________________
During menstruation, do you pass blood clots? ____ Yes ____ No How often? ________
How would you describe your cramping? ____ None ____ Mild ____ Moderate _______ Severe
At what point in your cycle?
____
Have you noticed any recent changes to your cycle? If yes, explain:
____
Do you experience any unusual or excessive vaginal discharge throughout the month?
____ Yes ____ No When?
____
Do you ever experience itching or odor in the vaginal area? ____ Yes ____ No
When?
____
____
Do you experience any breast tenderness? ____ None ____ Mild ____ Moderate _______ Severe
If yes, at what point in your cycle?
____
Do you have nipple discharge at any point in your cycle? ____ Yes ____ No
If yes, at what point in your cycle? _______________________ Color?
____

Menopausal Women

What age were you at the onset of menopause? ______ Year of onset? _______________
Date of your last menstrual period? ________________
Please describe any recent changes and / or symptoms associated with your cycle prior to Menopause:
____
____
____

Please list any and all GYN surgeries: What was the reason for each surgery?
1. ____
____
2. ____
____
3. ____

____
4. ____
____
5. ____
____

Please give an in depth explanation of how you perceive your experience transitioning into menopause: (for example, please list symptoms, emotional changes, thoughts, stressors, etc.)

____
____

Are you currently, or have you ever used conventional hormone replacement (HRT)?
____
If yes, please list the name of the prescription:
____
What is / was the dosage? ________________ For how long?
____
Are you currently, or have you ever used, bio-identical hormone creams / gels / sublingual,
troche, oral? ____ Yes ____ No
If yes, please list the name(s) of each product:
____
What is / was the dosage? ___________________________ For how long?
____
Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? ____ Yes ____ No
If yes, please list the name(s) of each product:
____
What is / was the dosage? ___________________________ For how long?
____
Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? ____ Yes ____ No
If yes, what?
____
Treatment:
____
Below please describe your cycle history:
Would you have described your menstruation as: Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy
When you were cycling would you describe your cycle as regular? ____ Yes ____ No
If no, please give explanation:
____
____

In the past, if you have ever received any type of “treatment” for any cycle issues would you please explain:
____
____
____

Sleep

How well do you sleep? Well   Trouble falling asleep   Trouble staying asleep   Insomnia

What is the average number of hours you most often sleep each night? _______
Do you wake up with night sweats? ____ Yes ____ No
When you wake in the morning do you still feel tired? ____ Yes ____ No
If yes, how often?
____
Do you keep your room completely dark at night? ____ Yes ____ No

Signs & Symptoms

(Instructions: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month) 2 = Moderate (happens weekly), 3 = Severe (happens almost daily) If you do not know an answer to a question or if it does not pertain to you simply leave it blank.

Section 1:

Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestion?	1	2	3
Uncomfortable / adverse reactions to food:	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water retention?	1	2	3
Belching / gas? (circle)	1	2	3
Stomach burning / nausea? (circle)	1	2	3

Section 2:

Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3

Diarrhea?	1	2	3
Persistent gas?	1	2	3
Digestive problems?	1	2	3

Section 3:

Low blood sugar / hypoglycemia?	1	2	3
Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine / stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

Section 4:

Low mood / depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger / aggression? (circle)	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

Section 5:

Discouragement / pessimism? (circle)	1	2	3
Decreased interest in activities / relationships? (circle)	1	2	3
Decreased initiative / motivation / drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue	1	2	3
Lowered self-esteem / self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness / crying? (circle)	1	2	3

Section 7:

Decrease in strength / stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decreased lean muscle mass?	1	2	3
Muscle soreness / weakness? (circle)	1	2	3
Body / joint aches? (circle)	1	2	3
Increased fat on hips / breasts / thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches / migraines? (circle)	1	2	3
Muscle pain / joint aches / backache? (circle)	1	2	3

Section 9:

Head hair loss / body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Section 10:

Infertility?	1	2	3
Lowered / heightened libido? (circle)	1	2	3
Hot flashes?	1	2	3
Night sweats?	1	2	3
Palpitations?	1	2	3
Breast tenderness?	1	2	3
Breast cysts?	1	2	3
Vaginal infections / yeast infections? (circle)	1	2	3
Urinary frequency / incontinence / infections? (circle)	1	2	3
Changes to labia / clitoral tissue? (circle) (Atrophy, thinning, discoloration, itching, burning)	1	2	3
Vaginal changes (dryness, tearing,decreasing size)? (circle)	1	2	3
Bone loss / osteoporosis?	1	2	3
Endometriosis?	1	2	3
Pelvic inflammatory disease?	1	2	3
Cystitis?	1	2	3
Ovarian cysts?	1	2	3
Fibroids?	1	2	3
Celiac Disease?	1	2	3
Lyme Disease?	1	2	3
Weak Immune system?	1	2	3
Liver Dysfunction?	1	2	3
Sinusistis?	1	2	3
Itchy/Watery Eyes?	1	2	3
Asthma?	1	2	3

Informed Consent Agreement (CBT)

I understand that I should not discontinue any health care provided by other health care providers, and that I should fully inform other health care providers about any changes in my symptoms or conditions that result from the application of CBT procedures. I understand that I may discontinue my CBT treatment at any time. However, I understand that the premature termination of my care may be detrimental to any improvement I have obtained.

I understand that Dr. Hamel is a chiropractic physician, and no a medical doctor or a doctor of osteopathy, and she does not practice medicine. I understand that CBT techniques and procedures were developed by Dr. Smith DC, and that they are an experimental, alternative form of healthcare which is not yet proven by medical science, not yet subjected to chiropractic peer review nor taught in chiropractic colleges, and are not covered by any health insurance, Medicare or Medicaid.

I have read the above statements, and I have been provided the opportunity to as any questions regarding CBT procedures. I have also been informed that I am to notify Dr. Hamel if I develop any problems during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of care. By signing below, I agree to the terms set forth above.

I have executed the foregoing this ____ day of ____________________

____________________________ ____________________________________

Signature Printed Name

____________________________ ____________________________________

If Minor, signature of parent or guardian Guardian's printed name

____________________________ ____________________________________

Witness signature Witness Printed Name