

FEMALE HEALTH HISTORY & SYMPTOMS

For CDSS Round 1

PATIENT INFORMATION

Name: _____ Date: _____
 Date of Birth: _____ Age: _____ Weight: _____ Height: _____

PATIENT QUESTIONS

Currently pregnant or trying to conceive? Yes No
 Had a recent mammogram (within last 12 months)? Yes No
 Have you had a hysterectomy? Yes No
 If so, type of hysterectomy: Complete (uterus and ovaries removed) Partial (uterus only removed)
 Had menstrual cycle (within last 12 months)? Yes No
 Had endometrial ablation? Yes No
 Are you on birth control? Yes No Name of birth control: _____
 Are you currently utilizing BHRT or HRT? Yes No
 If yes, select types of hormones: Testosterone Progesterone Estrogen Thyroid
 List name and dose of hormone(s): _____
 Are you currently on statins? Yes No
 Are you a smoker? Yes No
 Are you currently on oral nitrates? Yes No

MEDICAL HISTORY

Select all that apply:

Cardiovascular Conditions:

- Heart Attack or Stroke (within last 6 months)
- Tachycardia
- DVT or Blood Clot (within last 6 months)
- Hypertension
- Hyperlipidemia
- Obstructive Sleep Apnea
- Atrial Fibrillation

Gynecological Conditions:

- Pre-Menstrual Syndrome
- Endometriosis or History of Endometriosis
- Fibrocystic Breast Disease
- Fibroids or History of Fibroids
- Polyps or History of Endometrial Polyps

Cancer:

- Breast Cancer or History of Breast Cancer
- Endometrial Cancer
- Cervical Cancer
- Ovarian Cancer
- Thyroid Cancer or History of Thyroid Cancer
- Except for Basal Cell Carcinoma, Any Other Cancers?

Neurological Conditions:

- Epilepsy or Seizure Disorder
- Depression/Anxiety
- Psychiatric Conditions
- Migraine with Aura
- Meningioma

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MEDICAL HISTORY

Endocrine and Metabolic:

PCOS
Diabetes Type 2 or Insulin Resistance
Hyperthyroid
Hypothyroid
Multiple Endocrine Neoplasia Type-2

Autoimmune Conditions:

Diabetes Type 1
Hashimoto's Thyroiditis
Graves' Disease
Rheumatoid Arthritis
Multiple Sclerosis
Systemic Lupus (Erythematosus)
Psoriasis
IBS (Irritable Bowel Syndrome)
Crohn's Disease
Ulcerative Colitis

Organ Specific Conditions:

Liver Disease or History of Liver Disease
Kidney Disease or History of Kidney Disease
LAM (Lymphangiomyomatosis)
Osteoporosis or Osteopenia
HIV
Hepatitis
Hemochromatosis
Pancreatitis or History of Pancreatitis
History of or Gall Bladder Disease
Polycythemia Vera (PV)

SYMPTOMS AND CONCERNS

Select all that apply:

Hot Flashes	Cold Hands or Feet
Night Sweats	Brittle Nails
Vaginal Dryness	Dry or Flaking Skin
Decreased Interest in Sex	Lack of Energy (Fatigue)
Inability To or Delayed Orgasm	Decreased Muscle Mass
Painful Intercourse	Acne
Urinary Incontinence	Facial Hair
Frequent Urinary Tract Infection	Dry Eyes
Breast Tenderness	Joint Pain
Weight Gain	Difficulty Sleeping
Hair Loss	Mind Racing at Bedtime
Hair Thinning	Eating When Stressed
Thinning Eyebrows	