Changewater Wellness Center

Health History Questionnaire, Female

This is a confidential record of your history which will be kept in this office. Information herein will not be released to any person unless you have authorized us to do so as outlined in the privacy policy.

This is a fillable form pdf. Please fill in the shaded areas, save the file, and return via email.

Date _____

Name (Last) _____ First _____

Before each item below please list severity of issue.
Range 0 – 10 (0 = not an issue, 10 = severe issue). Note location if specific.

Menstrual History

____ Age of first period
____ Length of cycle (menses to menses)
____ Regular periods
____ Irregular periods
____ Blood clots (size: nickel, dime, quarter, strings)
____ Excessive bleeding
____ Spotting between periods
____ Start & stop bleeding
____ Average number of days of bleeding
____ Lack of period for 2 months or more
____ Painful Periods
____ Dark or brown blood at start of period
____ Dark or brown blood at end of period
____ Ovulation Pain or discomfort
____ Irregular Ovulation

Other: _____
_____
_____
_____
_____

PMS Symptoms

____ Anxiety
____ Depression
____ Edema
____ Cravings
____ Mood Swings
____ Acne with menses
____ Breast tenderness
____ Nausea
____ Dizziness

Other: _____
_____
_____
_____
_____

How frequently do you douche and with what? _____
_____

Have you ever been diagnosed with any of the following:

____ Endometriosis
____ Uterine Fibroids
____ Ovarian cysts
____ Candida
____ Unusual PAP
____ Candida
____ Vaginal infection or discharge
____ Cervical dysplasia
____ Polycystic Ovarian Syndrome (PCOS)
____ Prolapsed uterus or any other prolapse
____ Polyps
____ Pelvic Inflammatory Disorder (PID)
____ Tipped/Displaced Uterus
____ Uterine Infection
____ Herpes
____ Vaginitis
____ Fertility Issues

Other: _____
_____
_____
_____
_____

Breast Health

____ Tenderness
____ Fibrocystic breasts
____ Lumps or cysts

Sexual Intercourse

____ Lack of Libido
____ Painful Intercourse

History

____ How many pregnancies?
____ Hysterectomy
____ D&C
____ How many births?
____ Tubal Ligation

Is there a history of miscarriages or abortion? _____
Other surgeries/procedures _____
_____
_____

Birth Control or Hormonal Replacement
List all that you have used and for how long.

_____
_____
_____
_____

Complete this section only if menopausal or peri-menopausal:

If menopausal, date of last period _____

____ Peri-menopause
____ Memory Loss
____ Night Sweats
____ Day Sweats
____ Hot Flashes
____ Palpitations (what time_____)
____ Insomnia
____ Depression
____ Vaginal dryness
____ Mood Swings
____ Scattered thinking
____ Fatigue
____ Skin/Hair changes
____ Osteoporosis
____ Excess Vaginal Discharge

Other: _____

_____

_____

_____

_____