MRN: ____________________ Date: ____________________

Associates in Women's Health Care
PATIENT HEALTH QUESTIONNAIRE

Name ______________________________ Date of Birth ______________

Weight ____________ Height ____________

Current/Past Medical Problems (include surgeries) ______________________________

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Current Medications - Also list herbal supplements (i.e., Black Cohash) you are taking that may affect your hormones.
Continue on the back of this form if necessary.

Name of Medication	Dosage (mg's)
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________
______________________	____________

Menstrual History (Please circle)

Regular cycles
Irregular cycles
No cycles
First day of last menses ______________

Hysterectomy When ____________
Ovaries removed – one both When ____________
If no cycles, how long has it been? ____________

Symptoms – Please circle if you are experiencing any of the following: 1 = mild, 2 = moderate, 3 = severe

Symptom	Rating	Symptom	Rating	Symptom	Rating
Hot Flashes	1 2 3	Water Retention	1 2 3	Depressed	1 2 3
FoggyThinking	1 2 3	Decreased Stamina	1 2 3	Headaches	1 2 3
Heart Palpitations	1 2 3	Puffy Eyes/Face	1 2 3	Evening Fatigue	1 2 3
Aches/Pains	1 2 3	Allergies	1 2 3	Rapid Heartbeat	1 2 3
Decreased Libido	1 2 3	Sugar Craving	1 2 3	Urinary Urgency	1 2 3
Mood Swings	1 2 3	Loss Scalp Hair	1 2 3	Anxious	1 2 3
Vaginal Dryness	1 2 3	Uterine Fibroids	1 2 3	Weight gain-hips	1 2 3
Tearful	1 2 3	Decreased Muscle Size	1 2 3	High Cholesterol	1 2 3
Sleep Disturbed	1 2 3	Morning Fatigue	1 2 3	Stress	1 2 3
Weight gain-waist	1 2 3	High Blood Pressure	1 2 3	Bleeding Changes	1 2 3
Night Sweats	1 2 3	Nervous	1 2 3	Memory Lapse	1 2 3
Fibrocystic Breasts	1 2 3	Bone Loss	1 2 3	Rapid Aging	1 2 3
Irritable	1 2 3	Increased Facial Hair	1 2 3	Incontinence	1 2 3

Other ______________________