# Functional Health Institute

## Female Health History

Patient Name: _____

Please take your time in filling out these forms as honestly and accurately as possible.

**PLEASE SELECT THE FREQUENCY OF CONSUMPTION OF THE FOLLOWING:**

| | | | | |
|---|---|---|---|---|
| Soda or carbonated beverages: | Daily | Few /Week | Few /Month | Never |
| White flour products: | Daily | Few /Week | Few /Month | Never |
| Fried foods: | Daily | Few /Week | Few /Month | Never |
| Coffee: | Daily | Few /Week | Few /Month | Never |
| Fast foods: | Daily | Few /Week | Few /Month | Never |
| Sweets / refined carbohydrates: | Daily | Few /Week | Few /Month | Never |
| Beer / wine: | Daily | Few /Week | Few /Month | Never |
| Hard alcohol: | Daily | Few /Week | Few /Month | Never |
| Tobacco products: | Daily | Few /Week | Few /Month | Never |

Are you a vegetarian: Yes No

Are you currently involved in an exercise program: Yes No

**Please list any allergies**:

**HISTORY:**

Please select if you have or ever had any of the following:

| | | | |
|---|---|---|---|
| ☐ | Anemia | ☐ | Hysterectomy (Ovaries removed? Yes No) |
| ☐ | Appendicitis | ☐ | Kidney infection |
| ☐ | Arthritis | ☐ | Lichen Sclerosis |
| ☐ | Cancer (specify) | ☐ | Liver problems |
| ☐ | Chronic bronchitis | ☐ | Loss of balance |
| ☐ | Chronic headaches | ☐ | Neurological problems |
| ☐ | Colitis | ☐ | Ovarian cysts |
| ☐ | Diabetes | ☐ | Parasitic infections |
| ☐ | Endometriosis | ☐ | Pneumonia |
| ☐ | Fibrocystic Breasts | ☐ | Polycystic Ovarian Syndrome |
| ☐ | Gall bladder problems | ☐ | Seizures |
| ☐ | Heart disease | ☐ | Thyroid problems |
| ☐ | Hepatitis | ☐ | Ulcers |
| ☐ | Herpes Simplex, Fever Blisters, Cold Sores | ☐ | Uterine Fibroids |
| ☐ | High blood pressure | ☐ | Vulvodynia |

**REPRODUCTIVE HEALTH HISTORY:**

Age at onset of first period: _____

If you are currently using contraception, please list what form: _____

Have you ever used any of the following hormone contraceptives?

Oral ◯ Yes ◯ No From: _____ To: _____ Side effects: _____

Injected ◯ Yes ◯ No From: _____ To: _____ Side effects: _____

Patch ◯ Yes ◯ No From: _____ To: _____ Side effects: _____

Ring ◯ Yes ◯ No From: _____ To: _____ Side effects: _____

Have you ever used "the day after" pill? ◯ Yes ◯ No

Have you used, or are you currently using, an IUD? ◯ Yes ◯ No

If so, when? _____ For how long? _____

While under the use of any and all birth control methods, please select any of the following that you experienced:

☐ yeast ☐ mood swings ☐ fatigue ☐ palpitations ☐ heavy/light bleeding

☐ acne ☐ weight gain ☐ depression ☐ sweet cravings

If explanation is needed, please elaborate:

_____

_____

Are you currently using, or have you ever used, fertility treatment? ◯ Yes ◯ No

If yes, please elaborate:

_____

_____

Please describe any of the following bio-identical hormones you have used or are using:

| Hormone | Dosage | Length of Use |
|---|---|---|
| DHEA | _____ | _____ |
| Pregnenolone | _____ | _____ |
| Progesterone | _____ | _____ |
| Estrogen | _____ | _____ |
| Testosterone | _____ | _____ |
| Other _____ | _____ | _____ |

Do you have a history of abnormal Pap tests? ◯ Yes ◯ No

If yes, please elaborate and describe treatment and/or medication:

_____

_____

_____

Do you have a history of vaginal infections? ◯ Yes ◯ No

If yes, please elaborate and describe treatment and/or medication:

_____

_____

_____

**PREGNANCY HISTORY**

Have you ever been pregnant? ◯ Yes ◯ No (If "no," please skip to the next section.)

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____ Number of weeks gestation: _____ _____ _____ _____

Number of premature births: _____

Number of cesarean births: _____

Number of stillbirths: _____

Number of ectopic pregnancies: _____

If you have children, please list their ages: _____

**Cycling History (If you are menopausal, omit this section and skip to "Menopausal Women" below.)**

Date of your last menstrual period: _____

Please select how many days your current cycle is counting from the first day of this cycle to the first day of your next cycle: ◯ Less than 20 days ◯ 20-30 days ◯ 30-40 days ◯ 40-50 days ◯ More than 50 days

Number of days your menstruation typically lasts: _____

Would you describe your menstruation as: ◯ easy ◯ uncomfortable ◯ difficult ◯ debilitating

During menstruation, do you pass blood clots? ◯ Yes ◯ No If yes, how often? _____

At what point in your cycle do you experience cramping? _____

Have you noticed any recent changes to your cycle? ◯ Yes ◯ No If "yes," explain:

_____

During menstruation, if you experience any vaginal discharge other than blood, please explain:

_____

Do you experience itching or odor in the vaginal area? ◯ Yes ◯ No If "yes," when? _____

Do you have nipple discharge at any point in your cycle? ◯ Yes ◯ No

If so, at what point in your cycle? _____ Color? _____

Do you experience breast tenderness at any point in your cycle? ◯ Yes ◯ No

If so, at what point in your cycle? _____

**MENOPAUSAL WOMEN *(If you still have a cycle, do not complete this section.)***

Age at onset of menopause? _____ Year of onset? _____

Please describe any recent changes and/or symptoms associated with your cycle:

_____

Please give an in-depth explanation of your experience transitioning into menopause (e.g., symptoms, emotional changes, thoughts, stressors, etc.):

_____

_____

_____

Are you currently, or have you ever used, conventional hormone replacement (HRT)? ◯ Yes ◯ No

If "yes," please list the prescription name, dosage, length of use: _____

Please select any of the following bio-identical hormone products that you have used are or using:

☐ Topical cream or gel ☐ Oral prescription ☐ Sublingual

| Name of product | Dosage | Length of usage |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are you currently, or have you ever used, any alternative, complementary, or natural remedies to treat your menopause? ◯ Yes ◯ No

| Name of product | Dosage | Length of usage: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Do you currently experience, or have you experienced, vaginal spotting or bleeding since beginning menopause?

◯ Yes ◯ No

If yes, please describe: _____

Did you receive treatment? ◯ Yes ◯ No

If "yes," please describe: _____

Would you have described your menstruation as: ◯ easy ◯ uncomfortable ◯ difficult ◯ debilitating

When you were cycling, 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 explain: _____

If you received any type of "treatment" for cycle issues in the past, please explain:

_____

_____

_____

**SLEEP:**

Number of hours you typically sleep each night: _____ Do you sleep well? ◯ Yes ◯ No

Do you keep your room completely dark at night? ◯ Yes ◯ No

**SURGERIES, ACCIDENTS, TRAUMAS:** Please list any you have had and include dates.

_____

_____

_____

_____

_____

_____