FOR WOMEN ONLY

I. Menstrual Symptoms

Do you have?

Breast tenderness?	□ Yes □ No
Fluid retention?	□ Yes □ No
Hot flashes?	□ Yes □ No
Night sweats?	□ Yes □ No
Cravings?	□ Yes □ No
Menstrual cramps?	□ Yes □ No
Bloating?	□ Yes □ No
Anxiety?	□ Yes □ No
Insomnia?	□ Yes □ No
Heart palpitations?	□ Yes □ No
Mood Swings?	□ Yes □ No
Weight Gain?	□ Yes □ No
Headaches?	□ Yes □ No
Fatigue?	□ Yes □ No
Irritability?	□ Yes □ No
Depression?	□ Yes □ No
Forgetfulness?	□ Yes □ No
Crying?	□ Yes □ No
Have any of the above symptoms caused you to be unable to carryout your daily responsibilities?	□ Yes □ No

II. Menstrual Periods

What was the date of your last normal menstrual cycle?	_____
At what age did your menstrual periods start?	_____years old.
Do you still have menstrual periods?	□ Yes □ No
Do your menstrual periods occur at about the same time each month?	□ Yes □ No
If no, what is the shortest number of days between periods?	_____days.
If no, what is the longest day between periods?	_____days.
How long have your cycles been irregular?	_____months to _____years
Were your menstrual cycles ever regular?	□ Yes □ No
If yes, when?	_____
How many days do your periods last?	_____days.
Are your periods heavier or lighter than in the past?	□ Heavier □ Lighter
If so, when did they change?	_____/_____(month/year)
Do you have bleeding that occurs between your normal periods?	□ Yes □ No

III. Breasts

Do you feel your breasts are droopy?	□ Yes □ No
Are your breasts swollen, tender or painful before your periods?	□ Yes □ No
Do you have fibrocystic breast disease?	□ Yes □ No
If so, for how long?	_____
Have you had an abnormal discharge from your breasts?	□ Yes □ No
If yes, what color?	_____
If yes, for how long?	_____/_____(month(s)/year(s)
Have you had lumps in your breasts?	□ Yes □ No
Have you ever had a biopsy?	□ Yes □ No
If yes, how many times?	_____
If yes, when?	_____
Have you had your breast(s) aspirated?	□ Yes □ No
If yes, how many times?	_____
Do you have breast implants?	□ Yes □ No
If yes, when was the surgery performed?	_____
Are they saline or silicone?	□ Saline □ Silicone

IV. Bladder/Ovaries/Vagina/Uterus

Do you urinate frequently?	□ Yes □ No
Do you get recurrent bladder infections?	Frequently Occasionally Rare
Do you lose urine when you cough of sneeze?	□ Yes □ No
Have you had ovarian cysts?	□ Yes □ No
If yes, how many times?	
Have you ever had endometriosis?	□ Yes □ No
If yes, for how long?	_____/_____(month(s)/year(s)
Have you ever had uterine fibroids?	□ Yes □ No
If yes, for how long?	_____/_____(month(s)/year(s)
Do you have vaginal dryness?	□ Yes □ No
If yes, for how long?	_____/_____(month(s)/year(s)
Have you had a hysterectomy?	Yes / No Date of Surgery_____
Were you ovaries removed?	□ Yes □ No

V. Birth Control

Have you had a tubal ligation?	□ Yes □ No
If yes, when?	_____/_____(month(s)/year(s))
Have you ever used birth control pills?	□ Yes □ No
If yes, for how long?	_____/_____(month(s)/year(s))
Have you discontinued taking birth control pills?	□ Yes □ No
When did you discontinue taking birth control pills?	_____/_____(month(s)/year(s))
Are you currently using an IUD?	□ Yes □ No
Have you ever taken Depo-Provera?	□ Yes □ No
Are you currently taking estrogen?	□ Yes □ No
Are you currently taking progesterone?	□ Yes □ No
Are you currently taking any other hormones?	□ Yes □ No
If yes, which one(s)?	_____

VI. Sex

Do you have a decrease in sexual desire?	□ Yes □ No
If yes, for how long?	_____/_____(month(s)/year(s))
Do you find it more difficult to achieve orgasm?	□ Yes □ No
Are you able to achieve orgasm?	□ Yes □ No
Do you feel like making love less often than you used to?	□ Yes □ No
Is sexual intercourse as pleasurable as it used to be?	□ Yes □ No
Have you ever had pain during intercourse?	□ Yes □ No
Have you ever had pain after intercourse?	□ Yes □ No
Is the pain due to vaginal dryness?	□ Yes □ No

VII. Pregnancy

How many pregnancies have you had?	_____
How many live births have you had?	_____
How many miscarriages have you had?	_____
How many children do you have?	_____
What is the date of your last child's birth?	_____
How old were you at the time of your last delivery?	_____years old.
Did you have difficulty becoming pregnant?	□ Yes □ No
Did you ever receive infertility treatment?	□ Yes □ No
If yes, what kind?	_____