

Back In Action Chiropractic

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Female Hormone Questionnaire (March 2011)

Name: _____ Date: _____

Age: _____ Weight: _____

Medications currently taken: _____

Natural supplements or remedies currently taken: _____

General hormone questions:

1. At what age did you begin menstruating (onset of menarche)? _____
 - a. Number of days in cycle? _____
 - b. How many days bleeding? _____
2. Have you ever been pregnant? Y / N
 - a. How many times? _____
 - b. Number of children and ages: _____
 - c. Have you ever had any miscarriages or ectopic pregnancies? Y / N
If so, when? _____
3. Have you used the following contraceptives: Oral / Injected / Patch
When and for how long? _____
For what reason? _____
4. Do you have any discomfort, PMS, or other symptoms around the time of your period?
(If you know around what time, please include the day number in the menses cycle.)

5. Bleeding problems
 - a. Heavy bleeding (saturated tampons or pads more than 4 times per day)? Y / N
If yes, for how many days? _____
 - b. Spotting? Y / N (If yes, for how many days? _____)
 - c. Clotting? Y / N

d. Cramping? Y / N (If yes, when in the cycle? _____)

e. Other symptoms associated with bleeding? _____

6. List GYN procedures or surgeries. (Ovaries, hysterectomy, breast, other). Include dates and reasons.

Please indicate whether the following symptoms apply to you

- | | |
|--|---|
| <input type="checkbox"/> Mood swings: Mild / Moderate / Severe (Circle) | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Irritability: Mild / Moderate / Severe | <input type="checkbox"/> Constipation (1x/day or less) |
| <input type="checkbox"/> Anxiety: Mild / Moderate / Severe | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Short Fuse: Severe temper / Rage / Aggression | <input type="checkbox"/> Muscle/joint aches and pains |
| <input type="checkbox"/> Overly sensitive | <input type="checkbox"/> Back ache |
| <input type="checkbox"/> I take care of everyone else in my life except myself | <input type="checkbox"/> Headaches or migraines |
| <input type="checkbox"/> Depression: Mild / Moderate / Severe | When and how often? _____ |
| <input type="checkbox"/> Lessen Self-esteem or self-image | _____ |
| <input type="checkbox"/> Sadness <input type="checkbox"/> Crying | Specific times during your cycle? _____ |
| <input type="checkbox"/> Bloating <input type="checkbox"/> Water retention | _____ |
| <input type="checkbox"/> Memory difficulties | <input type="checkbox"/> Nausea or vomiting |
| <input type="checkbox"/> Foggy thinking <input type="checkbox"/> Lack of concentration | <input type="checkbox"/> Acne <input type="checkbox"/> Oily skin |
| <input type="checkbox"/> Cravings: Sweets, Carbohydrates, Chocolate | <input type="checkbox"/> Excessive facial hair <input type="checkbox"/> Excessive body hair |
| <input type="checkbox"/> Candida (Yeast Infections) | <input type="checkbox"/> Change in libido: Increased / Decreased |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Hyperglycemia (Diabetes) | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Weight Gain <input type="checkbox"/> Overweight | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Dry eyes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Painful intercourse |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary incontinence |

Any other symptoms related to your cycle or concerns not covered in this questionnaire? (Use back if needed)
