200 E Uwchlan Ave
Exton, PA 19341
(610) 363-7474
www.lionrx.com

Women's Health Questionnaire

General Information

Name_____Date of Birth_____

Address_____

City_____State_____Zip_____

Email_____

Phone_____□ Home □ Cell □ Work

Height_____Weight_____Blood type(if known)_____

Allergies_____

Occupation_____

Living Status □ Married □ Single □ Divorced □ Widowed

Current Health Status □ Excellent □ Good □ Fair □ Poor

Primary Physician_____Phone_____

Specialty Physicians (List phone number if known)

1. _____
2. _____
3. _____

Medical History

Main symptoms and duration

_____

_____

_____

Current Medical Conditions

-
-
-
-
-
-
-

Current Medications & Supplements (dosage & frequency if known)

-
-
-
-
-
-
-
-

Family History

Relative	Important diseases	Living	Deceased
Mother			
Father			
Sister(s)			
Brother(s)			
Aunt(s)			
Uncle(s)			
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Gynecological History

Age at 1st period_____Date of last period_____

Date of last pelvic exam_____Pap smear_____

Results_____

Abnormal Pap smears □ Yes □ No How many _____

Abnormal mammograms □ Yes □ No How many_____

Tubal ligation □ Yes □ No

Hysterectomy □ Yes □ No

Sexually active □ Yes □ No

Trying to conceive □ Yes □ No

Birth control use □ Yes □ No

If yes list method and duration_____

Side effects/problems_____

Average length of menstrual cycle_____days Days of flow____

Characteristic flow □ None to Mild □ Moderate □ Heavy □ Sever

Cramping □ None to Mild □ Moderate □ Heavy □ Severe

PMS symptoms_____

Starting time in cycle_____Finishing time in cycle_____

Current changes in cycle_____

Bleeding between periods □ Yes □ No

If yes, when_____

Pelvic pain, pressure, or fullness □ Yes □ No

If yes, describe_____

Unusual vaginal discharge/itching □ Yes □ No

If yes, describe symptoms & treatment

_____

Age at 1st pregnancy_____years old Full term pregnancies_____

If not full term, list problems_____

Miscarriages □ Yes □ No

Abortions □ Yes □ No

Which pregnancy (i.e. 1st, 2nd, 3rd)_____

How far along_____

Age mother started menopause_____ years old

Social History

Alcohol use □ No □ Yes Frequency_____

Tobacco use □ No □ Yes Frequency_____

Caffeine use □ No □ Yes Frequency_____

Illicit Drugs □ No □ Yes Frequency_____

Dietary Habits/Restrictions

Breakfast_____

Lunch_____

Dinner_____

Please Answer Yes or No to the following questions

Artificial sweetener use	□ Yes	□ No
Dental amalgam fillings	□ Yes	□ No
Root Canal(s)	□ Yes	□ No
Surgery(s)	□ Yes	□ No
Chemotherapy	□ Yes	□ No
Radiation therapy	□ Yes	□ No
Chlorinated Tap Water	□ Yes	□ No
Fluoride use	□ Yes	□ No
Pesticide application or use on lawn	□ Yes	□ No
Flu Shots or other vaccines	□ Yes	□ No
Lyme disease testing	□ Yes	□ No

Symptoms Part I

Rate your severity level for each symptom list

Symptom	Absent	Mild	Moderate	Severe
Vaginal dryness				
Shortness of Breath				
Dry hair or skin				
Hair Loss				
Short term memory loss				
Frequent UTIs				
Heart palpitations				
Frequent yeast infections				
Painful intercourse				
Inability to reach orgasm				
Tearful				
Food cravings				
Irritability/Moodiness				
Cramps				
Hot flashes				
Night sweats				
Weight gain				
Bloating				
Memory lapses				
Allergies				
Chemical sensitivity				

Stress				
Aches & Pains				
Arthritis/Joint Pains				
Loss of muscle mass				
Thinning skin				
Recurrent sinus infections				
Asthma/bronchitis				
Incontinence				
Excessive facial/body hair				
Loss of scalp hair				
Increased acne				
Oily skin				

Symptoms Part 2

Rate your severity level for each symptom listed

Symptom	Absent	Mild	Moderate	Severe
Fluid retention (edema)				
Afternoon fatigue				
Breast swelling				
Breast tenderness (frontal)				
Fibrocystic breast(s)				

Uterine fibroids				
Mood swings				
Heavy flow menses				
Irregular menstrual cycles				
Loss of sex drive				
Headaches (cyclical)				
Weight gain in hips/thighs				
Anxious/Nervous				
Sensitive				
Sweet cravings				
Salt cravings				
Constipation				
Cold hands/feet				
Low body temperature				
Dry skin & hair				
Fuzzy thinking				
Fatigue upon arising				
Infertility				
Fibromyalgia				

Brief description of your medical history in your own words

_____

_____

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