

Digestive system:

Please circle if you have any of the following: heartburn, nausea, constipation, diarrhea, bloody stool or hemorrhoids.

Genitourinary:

Do you lose any urine when you cough, sneeze or laugh? Y N

Do you ever lose any urine when you are trying to get to the bathroom but don't make it? Y N

Please check the severity of any of the following symptoms related to hormones:

	None	Mild	Moderate	Severe
PMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful or lumpy breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating or puffiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinning of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foggy thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinning skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sexual desire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sexual arousal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sexual response	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please indicate whether immediate relatives (parents, siblings, grandparents, aunts/uncles, cousins, children) have or have died of the following:

<i>Cancer:</i> Breast _____ Ovarian _____ Cervical _____ Uterine _____ Colon _____ Lung _____ Other _____	<i>Other Family History:</i> High Blood Pressure _____ Heart attack _____ Stroke _____ Diabetes _____ Osteoporosis _____ Alzheimer's _____ Liver disease _____	Mental Illness _____ Obesity _____ Thyroid _____ MS _____ Genetic disorders _____ Bleeding disorder _____ Other _____
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Please describe any other health issues you have that are not listed above:

<i>Cardiovascular</i> - high blood pressure, valve problems, stroke, blood disorders, anemia, blood clots, swollen legs or feet, chest pain	
<i>Head/Neck</i> - problems with hearing, ringing in ears, voice changes, sinus troubles, headaches, nosebleeds, vertigo, dry mouth, dentures, swollen glands	
<i>Respiratory</i> - Asthma, TB, short of breath, bloody sputum	
<i>Urinary tract/genitals</i> —frequent UTIs, kidney issues, STDs, vulvar issues, endometriosis, urinary urgency or frequency, incontinence	
<i>GI system</i> - pain with bowel movements, gallbladder, ulcers, food intolerance, hemorrhoids, constipation, diarrhea	
<i>Neurological</i> - Seizures, numbness, weakness in a body part, fainting spells, dizziness, trouble with balance, tremors	
<i>Liver Problems</i> - hepatitis, history of mono, alcoholism	
<i>Bone or muscle issues</i> - arthritis, old injuries that ache, chronic back pain, loss of mobility or range of motion, swollen or hot areas, bony growths, etc	
<i>Skin issues</i> - psoriasis, eczema, skin cancer, itching, rash, etc	
<i>Emotional</i> - frequent crying, anxiety, difficulty concentrating, sleep disturbances, irritability, depression, bipolar, etc	
<i>Endocrine</i> - thyroid problem, diabetes, sweaty palms, hot or cold intolerance, unexplained weight changes, increase in body hair	

Have you had a colonoscopy or sigmoidoscopy? Y N If yes, when was your last one? _____
 When was the last time you had your cholesterol checked? _____ Never
 Last TB test _____ Never

These are questions we ask everyone because it is so common among women.....

Have you been hit, slapped, kicked, or otherwise physically hurt by someone in the last year? Y N
 Within the past year, has anyone forced you to do sexual activities? Y N
 If yes to either of these questions, are you willing to discuss it with Blue? Y N Maybe later

Do you drink alcohol? Y N If so, how many times a week? _____ How many drinks each time? _____
 Do you smoke cigarettes? Y N How many per day? <1/2 pack > 1/2 pack per day >1 pack per day
 How many years have you smoked? _____ If you quit, when? _____
 Do you drink caffeine? Y N How many caffeinated sodas, coffees, and black teas per day? _____

Are you having any situational stressors or worries right now? Y N
 If yes, please circle the one that applies to you:
 Marital Work Financial Children Home Other _____

Do you get time to do hobbies and relaxation? Y N

What do you do for work? _____

What is the name of the health care provider you usually see? _____

*Thank you for taking the time to fill this out!
 Please bring it to your appointment*