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 when you are done and follow prompts.**

Women's Health Assessment

Please answer the following to the best of your ability. We appreciate your responses in creating a complete, holistic assessment of your general and reproductive health history.

***Place a "C" in front of all that applies to your CURRENT state of health**

***Place a "P" in front of all that applies to your PAST health history**

- ___ Irregular menses ___ Heavy menses ___ Scanty menses ___ Spotting ___ Fibroids ___ Ovarian cysts ___ Cramping
- ___ High Libido ___ Low Libido ___ Pain w/Sex ___ Loose stools ___ Constipation ___ Acne ___ PMS ___ Mood swings
- ___ Low appetite ___ Frequent breast tenderness ___ Breast swelling ___ Bloating ___ Vaginal dryness ___ Migraines
- ___ Frequent headaches ___ Poor vision ___ Vision changes ___ Dry eyes ___ Low back pain ___ Frequent thirst/hunger
- ___ Water retention/edema ___ Irritability ___ Depression ___ Anxiety ___ Nausea/Vomiting ___ Ear ringing ___ Seizures
- ___ Sleep disturbances/insomnia ___ Frequent nightmares ___ Hot flashes ___ Night sweats ___ Day sweats ___
- ___ Frequent yeast infections ___ Hair thinning ___ Dry/Brittle hair ___ Frequent urination ___ Frequent/chronic UTI
- ___ Scanty urination ___ Blood in urine ___ Dizziness ___ Anemia ___ Cold hands/feet ___ Crave Ice/Cold beverages
- ___ Dry Throat ___ Dry Skin ___ Thyroid disorder ___ Low energy ___ Hyper-energetic ___ Energy crashes ___ Bitter taste
- ___ Shortness of breath ___ Chest pain/tightness ___ Palpitations ___ Gall stones ___ Crave sweet/salty ___ Memory loss
- ___ Digestive complaints ___ Difficulty losing/gaining weight ___ Unclear/foggy thinking ___ Shaking/trembling

GYNECOLOGICAL HEALTH PROFILE: Perimenopausal or Postmenopausal? **Yes No**

- ___ # of days in your cycle (cycle length= first day of menstrual flow to first day of next menstrual flow)
- ___ # of days you bleed
- ___ LMP (1st day of last menstrual period)

What is the color/consistency of your menstrual blood (Please check all that apply):

Pale Red Bright Red Dark/Purple Thin/Watery Thick /Sticky Dark Clots Large Clots Small Clots

Pregnancy: Please enter: ___ # of Miscarriages ___ # of Abortions ___ # of Live Births

Is there any history of sexually transmitted infection(s)? **Y/N** If so, please list: **Yes No**

Were there any complications related to miscarriage, abortion or birth? **Y/N** If so, please explain briefly:

Please briefly list ANY MAJOR MEDICAL EVENTS: surgeries, illnesses and the approximate Age/Date at which they occurred, if need be, continue the list on the backside of this form:

Please briefly describe your vision of optimal health:

***Are you interested in taking herbs/supplements? Y/N**

***Would you like to receive mail/email regarding lectures, classes, coupons, gift certificates, and newsletters from our clinic? Y/N Yes No**