Female Hormone questionnaire

Patient name: _____ Date of Birth: _____

Self- referral or referred by: _____

Prior endocrinologist (if any): _____

Please bring this completed form along with a list of your current medications and supplements (or bring all your medication bottles) to your appointment.

1) **What is your chief concern that you would like addressed today?**
   _____
2) **When did it start?** _____
3) **How old where you when you got your first period?**
4) **Were your periods regular (i.e. every 28 days) initially?** _____Yes or_____ No
5) **Are your periods irregular now?** ____ Yes _____No

   If yes, explain_____
6) **Are you on birth control or any hormones?** _____Yes or _____No
7) **When was the start of your last period?** _____
8) **Are you taking biotin, hair, skin or nail supplements?** ____ Yes _____No
9) **Have you had an ovary or pelvic ultrasound?** ____ Yes _____No

   If yes, what was the result? _____
10) **Do you have a history of polycystic ovarian syndrome in your family?**
    ____ Yes _____No

Symptoms (Circle if you have had any in the last 1 month): Fatigue ____ fever ____

weight gain ____weight loss ____ hot flashes ____Vision changes ____ trouble

swallowing ____ hoarseness____

Dry skin ____ itchy skin____acne____ abnormal thick hair on face, back or chest ____

Chest pain____ shortness of breath ____ leg swelling ____ palpitations ____

Nausea____vomiting____diarrhea ____ constipation ____frequent bowel movements ____

Night time urination ____ frequent urination____

Anxiety ____ depression____

Intolerance to cold ____ intolerance to heat____ hair loss____

None of the above____