Institute for Health and Wellness

Kimberley A. Schroeder, D.O.
115 Baker Drive ● Tomball, TX 77375
281.290.0531
www.FeelWellAgain.com

FEMALE MEDICAL QUESTIONNAIRE
(PREMENOPAUSAL)

NAME: DATE OF BIRTH:

CHIEF COMPLAINT

- What is your primary problem?

  _____

  _____

- What kind of physicians have you seen for your health problem(s)?

  _____

  _____

PAST MEDICAL HISTORY

ILLNESS	YEAR	ILLNESS	YEAR
Y / N Cancer	_____	**Y / N** Irrit. Bowel Syndrome	_____
Y / N Chronic Fatigue Syndrome	_____	**Y / N** Kidney Disease	_____
Y / N Colitis	_____	**Y / N** Lupus	_____
Y / N Diabetes	_____	**Y / N** Mitral Valve Prolapse	_____
Y / N Elevated Cholesterol	_____	**Y / N** Mononucleosis	_____
Y / N Elevated Triglycerides	_____	**Y / N** Multiple Sclerosis	_____
Y / N Fibromyalgia	_____	**Y / N** Oral Yeast/Mouth Inf.	_____
Y / N Gall Bladder Disease	_____	**Y / N** Pelvic Inf. Disease	_____
Y / N Heart Disease	_____	**Y / N** Pneumonia	_____
Y / N Heart Attack	_____	**Y / N** Seizures	_____
Y / N HIV Positive	_____	**Y / N** Sex. Trans. Disease	_____
Y / N Hypertension	_____	**Y / N** Sleep Apnea	_____
Y / N Hyperthyroidism	_____	**Y / N** Stroke	_____
Y / N Hypothyroidism	_____	**Y / N** Tuberculosis	_____

Y / N Hepatitis _____ **Y / N** Ulcerative Colitis _____

LIFETIME ANTIBIOTIC USE

Approximately how many times have you used antibiotics over the past year? _____x
Over the past 5 yrs? _____x/yr 10 yrs? _____x/yr 20 yrs? _____

For what illness(es)? _____ What year? _____
How long did you take the antibiotics continuously? _____

Was there any time in the past when you used antibiotics for 30 days or longer continuously for acne or illness? Y / N

If for acne, did you take Accutane? Y / N For how long? _____

REVIEW OF SYMPTOMS

HEADACHES

Y / N Do you have headaches? _____x/week _____x/month For how long? _____
What do you take to relieve your headaches? _____

NOSE

Y / N Do you have colds, runny/stuffy nose, or sinus problems?
How often? _____x/week _____x/month
Y / N Do you snore? For how long? _____months _____years

ASTHMA

Y / N Did you ever have asthma or wheezing? How often? _____x/month_____x/year

HEART

Y / N Have you ever had a heart attack? When _____
Y / N Do you ever feel your heart skip a beat? How often? _____
For how many years? _____
Y / N Do you have chest pain? How often? _____
How long does the pain last? _____ How many years? _____
The pain is: sharp / stabbing / dull / aching
It radiate to your: neck / back / shoulders
Y / N Do you feel like you are going to pass out?

GASTROINTESTINAL SYSTEM

Y / N Do you have: abdominal cramping / bloating / excessive belching / intestinal gas? How often? _____x/week For how long? _____

URINARY TRACT

Y / N Have you ever had bladder infections/kidney infections?
How many x/year? _____ For how many years? _____
Y / N Have you ever had kidney stones? How many times? _____
Year of last episode _____
Y / N Do you have burning upon urination?
Y / N Do you have increased frequency of urination?

YEAST/SKIN FUNGUS

Y / N Have you ever had a vaginal yeast infection? How many times? _____
How many x/year? _____ For how many years?____

SKIN

Y / N Do you have any unexplained skin rashes or itchy skin?
For how long? _____months _____years
Do you know the cause of your rashes/itchy skin? _____
Y / N Do you have dry skin? For how many years? _____

THYROID

Y / N Have you been diagnosed with a thyroid disorder? Year diagnosed _____
Y / N Were you diagnosed with hyperthyroidism (high)?
Y / N Were you diagnosed with hypothyroidism (low)?
Y / N Did you ever take thyroid medication? What year did you quit? _____
Name of medicine _____

MALAISE/FATIGUE

Y / N Do you feel you should have more energy?
What is your average energy level on a scale of 1-10 with 10 meaning brimming with energy and 1 meaning the inability to get out of bed?
ENERGY LEVEL: _____/10 For how many years? _____

FLUID RETENTION

Y / N Do you have swelling beneath your eyes or dark circles under your eyes?
_____x/month For how many years? _____
Y / N Do you have swelling of your face, hands, or feet? _____x/month
For how many years? _____
Y / N Is this swelling related to your periods?

COLD SENSITIVITY

Y / N Do you have cold hands or feet? For how many years? _____
Y / N Are you sensitive to the cold or get chilled easily? For how many years? _____

SWEATING

Y / N Do the palms of your hands or feet perspire unusually?
For how many years? _____
Y / N Do you have decreased perspiration? For how many years? _____

HAIR CONDITION

Y / N Do you have coarse or fine hair? For how many years? _____
Y / N Have you ever had significant hair loss? For how long? _____months _____years

WEIGHT

Y / N Have you had significant weight gain? How many pounds? _____ pounds
Since what year? _____
Y / N Do you have difficulty losing weight? For how long? _____

COGNITIVE ABILITY

Y / N Do you ever feel that you have decreased mental sharpness?
Y / N Do you have a poor short-term memory?
For how many years have you had these problems? _____

MOOD

Y / N Do you ever feel discouraged, blue or depressed more than 10% of the time?
What percent of the time? _____% For how many years? _____
Y / N Have you ever taken anti-depressants?
Which one(s)? _____
Between what ages? _____ y.o. and _____ y.o.

BOWEL FUNCTION

Y / N Do you have a bowel movement every day?
How many times per week do you have a bowel movement? _____x/week
Y / N Do you alternate between constipation and diarrhea? How many years? _____

JOINT FUNCTION

Y / N Do you have pain in any joint(s)? Circle which of the following joints:

Neck	Lower Back	Elbows	Wrists	Finger joints
Shoulder	Hips	Knees	Ankles	Toe Joints

How many times per week? _____ For how many years? _____

MUSCLE

Y / N Do you have muscle weakness? For how many years? _____
Y / N Do you ever have generalized muscle aches/cramping? Which muscles?
_____
For how many years? _____
Y / N Do you have any numbness or tingling in the extremities?
Which ones? _____ For how many years? _____

SLEEP

Y / N Do you have insomnia or restless sleep? For how many years? _____
Y / N Do you feel tired after a full night's sleep? For how many years? _____
Y / N Do you have afternoon fatigue?
How many hours of sleep do you require? _____hours/night?

PREGNANCY

Date of last normal menstrual period? _____/_____/_____
At what age did you enter puberty? _____y.o.
How many pregnancies? _____live births? _____ miscarriages? _____
Date of last child's birth _____ Your age then? _____
Y / N Did you have difficulty becoming pregnant?
Y / N Did you ever receive infertility treatment? What kind? _____

BIRTH CONTROL

Y / N Have you had bilateral tubal ligation? If yes, when? _____/_____ (mo/yr)
Y / N Are you currently using an IUD?
Y / N Have you ever taken Depo-Provera?
Y / N Did you ever take birth control pills? If yes, for how long? _____ mos _____ yrs
Date you discontinued BCP _____/_____
Y / N Are you currently taking any female hormones (progesterone or estrogen)?
If yes, which ones? _____
For how long? _____

PAP SMEAR

Y / N Have you had an abnormal pap smear? If yes, when? _____/_____ (mo/yr)
Y / N Was your most recent pap smear normal? Date: _____/_____ (mo/yr)

MENSTRUAL PERIODS

Y / N Do your menstrual periods occur at the same time each month?

If no, what is the shortest number of days between periods? _____
What is the longest number of days between periods? ____
How long have your menstrual cycles been irregular? _____months _____years

Y / N Were your menstrual cycles ever regular?
How many days do your periods lasts? _____days

Y / N Are your periods heavier or lighter than in the past?
If yes, when did they change? _____ (mo/yr)

Y / N Do you have bleeding that occurs between your normal periods?
If yes, for how long has this occurred? _____months _____years

PREMENSTRUAL SYNDROME

Y / N Do you have breast tenderness prior to your periods?
If yes, how many days prior to your periods did it begin? _____days

Y / N Do you have mood swings prior to your periods?
If yes, how many days prior to your periods did it begin? _____days

Y / N Do you have fluid retention prior to your periods? For how many days prior to your period did it begin? _____days

Y / N Do you have weight/gain prior to your periods? How many pounds did you gain prior to your periods? _____lbs

Y / N Do you crave sweets, bread products, or salty foods prior to your periods?

Y / N Do you develop headaches prior to your periods? If yes, how many days prior to your period did they begin? _____days

Y / N Do you have menstrual cramps? If yes, for how many days? _____days

Y / N Do any of the above symptoms ever cause you to miss work or school, or cause you to be unable to carry out your daily responsibilities?

ESTROGEN DOMINANCE

Y / N Do you have fibrocystic breast disease? For how long? ____mos____yrs

Y / N Do you have endometriosis? For how long? ____mos ____yrs

Y / N Do you have uterine fibroids? For how long? ____mos ____yrs

Y / N Do you have ovarian cysts? How many times? _____
Which side? ____left ____right

Y / N Have you developed dark hair on your face or breast?
How long ago did it begin? ____mos ____yrs

Y / N Do you have hot flashes? How many times per month? _____x/month

Y / N Do you have night sweats? For how many years? _____

Y / N Have you had a decrease in your sexual desire? For how Long?
_____mos _____yrs

Y / N Do you have painful intercourse? Due to vaginal dryness? Y N
For how long? _____mos _____yrs

BREAST

Y / N Have you had a mammogram? How many? _____ Date of last _____/_____

Y / N Was your last mammogram normal?
If no, then what were the findings? _____

Y / N Have you had discharge from your breast? If yes, what color? _____
For how long? _____mos _____yrs

Y / N Have you had a breast biopsy? How many times? _____

Y / N Have you had your breast(s) aspirated? How many times? _____

Y / N Do you have breast implants? Saline / Silicon
If yes, when was the surgery performed? _____/_____