

Women's Questionnaire



Dr. Shel
WELLNESS & MEDICAL SPA

Date: _____ Referred By: _____
Name: _____ Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Home: _____
Cell: _____ Work: _____

Age: _____ D.O.B: _____ Social Security #: _____
Marital Status: M W D Sp S Occupation: _____
Date of Last Menstrual Period: _____ # of pregnancies _____ # of deliveries _____
Reason for Visit: _____

- Please check all applicable and explain:
- | | | |
|---------------------------------------------------|------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Excessive Weight | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental Health/Depression |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Chronic Yeast Infection |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Irrit. Bowel Syndrome | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Disorders |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Skin Complaints |

Health Maintenance: (Date last done)
Bone Density: _____ MMG _____ Pap _____
Lipid Profile: _____ Flex Sigmoidoscopy _____
Medical Problems: (Explained from above) _____

Name and number of Primary Care Physician _____
Current Medications/Supplements:

Birth Control Method _____ Hormones _____
Do you have any drug allergies? No Yes If yes, give reaction medication and reaction _____
Do you exercise? No Yes What kind? _____ How Often _____
Do you smoke? No Yes How much? _____ How Long? _____
Do you use alcohol? No Yes How much? _____ How Long? _____

Have you had a major illness/hospitalization/surgery? No Yes

Explain: _____

Is there a family history of: (Please check)

- Colon Cancer Ovarian Cancer Diabetes Breast Cancer
- High Blood Pressure Heart Disease Other _____

Are you interested in our other services:

- Nutritional testing Laser Rejuvenation Cellulite Treatment
- Weight Management Skin Care Mineral Makeup
- Allergy Testing Laser Skin Tightening Facial Treatments
- Massage/ PT Laser Hair Removal Laser Hair Regrowth

Children

Name and age of children

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Family History

	Medical Problem(s)	
Father- alive or deceased?	Age	_____
Mother- alive or deceased?	Age	_____
Brothers/sisters:		Medical Problem(s)
_____	Age	_____
_____	Age	_____
_____	Age	_____

REVIEW OF SYMPTOMS

Heart

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? _____
For how many years? _____

Is the pain sharp / stabbing / dull / aching? _____ Does it radiate to your neck, back, or shoulders?

Y N How long does the pain last? _____

Y N Do you feel like you are going to pass out?

Gastrointestinal System

Y N Do you have abdominal cramping, bloating, excessive belching or intestinal gas?

How often? ____ x/week _____ 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? ____ How many years? _____
Between what years? ____ and _____

Environmental Allergies

Y N Do you have environmental allergies such as: pollen, mold, cat, or dog?

Y N Have you had an allergy test performed? If yes, date:

Please list allergies below

- | | |
|----------|----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| _____ | _____ |

Thyroid

Y N Have you been diagnosed with a thyroid disorder? Year diagnosed _____

Y N Were you diagnosed with hyperthyroidism

Y N Were you diagnosed with hypothyroidism

Y N Did you ever take thyroid medication? What year did you quit? _____
Name of medicine _____ Dose _____ mg

Malaise/Fatigue

Y N Do you feel you should have more energy?
What is your average energy level on a scale of 0 to 10 with 10 meaning brimming

with energy
and 1 or 2 meaning the inability to get out of bed?
ENERGY LEVEL 0-10 _____ /10 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?
How long? _____ months _____ years

Weight

Y N Have you had significant weight gain? How many
pounds? _____
Since what year? _____
Y N Do you have difficulty losing weight? How long?
Y N Are you interested in medical weight
loss? _____

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 _____ y.o. and _____ y.o.
ages? _____

Skin

Y N Do you have dry skin? For how many years? _____

Sleep

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

MENSTRUAL HISTORY - PREMENOPAUSAL QUESTIONS

Pregnancy

Date of last normal menstrual _____ / _____ / _____
period?
At what age did you enter _____ y.o.
puberty? _____

How many pregnancies? _____ live _____ miscarriages?
_____ births? _____

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, _____ / _____ (mo/yr) when? _____

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 _____ months _____ years irregular? _____

Y N Were your menstrual cycles ever regular?

How many days do your periods last? _____ 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 intermenstrual bleeding that occurs between your normal periods?

If yes, for how long has this _____ month _____ years occurred? _____ s _____

Premenstrual Syndrome

- Y N** Do you have breast tenderness prior to your period?
If yes, how many days prior to your period does it begin? _____ days
For how long has this _____ months _____ years
occurred?
- Y N** Do you have mood swings to your period?
If yes, how many days prior to your period does it _____ days
begin? _____
For how long has this _____ months _____ years
occurred?
- Y N** Do you have fluid retention prior to your period?
If yes, how many days prior to your period does it _____ days
begin? _____
For how long has this _____ months _____ years
occurred?
- Y N** Do you have weight gain prior to your period?
Approximately how many pounds do you gain prior to your _____ lbs.
periods? _____
For how long has this _____ months _____ years
occurred?
- Y N** Do you crave sweets or bread products prior to your periods?
Y N Do you develop headaches (not migraine) prior to your periods?
If yes, how many days prior to your period do they _____ days
begin? _____
For how long has this _____ months _____ years
occurred?
- Y N** Do you have menstrual cramps? If yes, for how many days? _____
- Y N** Do you experience hot flashes? For how long? _____ months _____ years
- Y N** Do you have night sweats? For how _____
many years? _____
- Y N** Have any of the above symptoms ever caused you to miss work or school, or
cause you to be unable to do daily functions?

Estrogen Dominance

Y N Do you have fibrocystic breast disease? how long? _____ months _____ years

Y N Have you ever had endometriosis? how long? _____ months _____ years

Y N Do you have uterine fibroids? how long? _____ months _____ years

Y N Have you had ovarian cysts? How many times? _____
Which side? lef right

_____ t _____

Y N Have you developed dark hair on your face?
How long ago did it
begin? _____ months _____ years

Y N Have you developed dark hair on your breasts?

How long ago did it
begin? _____ months _____ years

Y N Have you had a decrease in sexual
desire?
For how long? _____ months _____ years

Y N Have you ever had pain or discomfort during or after intercourse?

Y N Due to vaginal dryness?
For how long? _____ months _____ years

Bone Density

Y N Have you ever been diagnosed with osteoporosis?

Recurrent Medications

Y N Do you currently take prescription medication? Please list the strength,
times/day taken, and number of years taken:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____

Y N Do you currently take vitamins or supplements? Please list the strength,
times/day taken, and number of years taken:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____

Dr. Shel's Weight Loss Questionnaire

What are your weight loss goals?

What weight loss methods have you tried previously?

How much weight did you lose? Are you happy with the results?

Please list your food intake on a typical day

	Breakfast	Snack	Lunch	Snack	Dinner
Time					
Foods					
Calories					

Please list your exercise routine for a typical week. Please list duration under each day.

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Cardio							
Weights							
Pilates							
Yoga							
Other							

Hormone Checklist

Check applicable symptoms of each category:

Estrogen Deficiency

- | | |
|------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Foggy Thinking | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Dry Skin/Hair |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Tearful | |

Estrogen Excess

- | | |
|------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Mood Swings (PMS) | <input type="checkbox"/> Fibrocystic Breasts |
| <input type="checkbox"/> Tender Breasts | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Water Retention | <input type="checkbox"/> Weight Gain (Hips) |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Bleeding Changes |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Cold Body Temperature | <input type="checkbox"/> Weight Gain waist |

PROGESTERONE DEFICIENCY

- | | |
|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Candida Infections | <input type="checkbox"/> Fluid Retention |
| <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stressed easily |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Water retention |

PROGESTERONE DEFICIENCY

- | | |
|---------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Break-thru bleeding |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Heavy Periods | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Irregular cycles |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Hypothyroidism |

Androgen Deficiency

- | | |
|------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Low libido | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Thinning Pubic Hair |
| <input type="checkbox"/> Aches/Pains/Arthritis | <input type="checkbox"/> Decreased Muscle Mass |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Thinning Skin |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Fibromyalgia |

Androgen Excess

- | | |
|-------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Excessive Facial Hair | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Excessive Body Hair | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Increased Acne | <input type="checkbox"/> Hair Loss scalp |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Nervous/Irritable |
| <input type="checkbox"/> Elevated Triglycerides | |

Cortisol Deficiency

- | | |
|-----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Body Temp. |
| <input type="checkbox"/> Sugar Cravings | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Aches / Pains |

Cortisol Excess

- | | |
|-------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Weight Gain/Loss | <input type="checkbox"/> Cold Body Temp |
| <input type="checkbox"/> Muscle Mass Loss | <input type="checkbox"/> Sugar Cravings |
| <input type="checkbox"/> Thinning Skin | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Increased Facial Hair |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Increased Body Hair |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Nervous |

THYROID DEFICIENCY

- | | |
|---------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Tired or Exhausted | <input type="checkbox"/> Difficult to Concentrate |
| <input type="checkbox"/> Sad or Depressed | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Cold Body Temp. eye/face | <input type="checkbox"/> Swelling/Puffy |
| <input type="checkbox"/> Cold Hands & Feet | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Slow Pulse Rate |
| <input type="checkbox"/> Can't Lose Weight | <input type="checkbox"/> Decreased Sweating |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Hair Dry/ Brittle |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Hair Loss |

THYROID DEFICIENCY

- | | |
|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Nails breaking/ Brittle | <input type="checkbox"/> Infertility Problems |
| <input type="checkbox"/> Aches / Pains | <input type="checkbox"/> Slowed Reflexes |
| <input type="checkbox"/> Low Libido | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heart Palpitation | <input type="checkbox"/> Thick Tongue |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Slow Ankle Reflex |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Decreased Muscle Mass | |
| <input type="checkbox"/> Thinning Skin | |