

Pelosi Medical Center

Female Health Assessment Questionnaire

NAME: _____

TODAY'S DATE: ____ / ____ / ____ PHONE: _____ EMAIL: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems (difficulty falling asleep or sleeping through the night)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decline in drive or interest (loss of "zest for life," feeling down or sad)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory (concentration, finding the right word, or retaining information)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness or difficulty with sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (night sweats or increased episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes (burst that starts in chest and lasts for short duration)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss, thinning or change in texture of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling cold all the time, having cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches or migraines (increase in frequency or intensity)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight (difficulty losing weight despite diet/exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other symptoms or unique health circumstances to take into consideration:
