FEMALES ONLY:

PMS Mod/Severe	Yes	No	Excessive Hair Growth Face/Body	Yes	No
Menstrual Cramps	Yes	No	Hysterectomy Partial/Full	Yes	No
Pelvic Pain	Yes	No	Decreased Libido	Yes	No
PCOS	Yes	No	Sexual Dysfunction	Yes	No
Pain with Intercourse	Yes	No	Ovarian or Uterine Cancer	Yes	No
Endometriosis	Yes	No	Vaginal Dryness	Yes	No
Uterine Polyps	Yes	No	History of Vaginal infections	Yes	No
Breast Pain	Yes	No	Abnormal Vaginal Discharge	Yes	No
Infertility	Yes	No	Recurrent UTIs	Yes	No
Ovarian Cysts	Yes	No	Sexually Active Monogamous Non-Monogamous	Yes	No
Breast Cancer	Yes	No	STD Treatment	Yes	No
Heavy Periods	Yes	No	Irregular Periods	Yes	No
Abnormal PAP	Yes	No	Bleeding between Periods	Yes	No

Additional information for any **Yes** Answers:

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PREMENOPAUSAL WOMEN: Last Menstrual Cycle: _____ Frequency of Cycle: _____ Duration of Cycle: _____

Age of Menarche: _____ Heavy days #:_____Pads/Tampons Used on Heavy days #: _____ Cramps: Yes/No Bloating: Yes/No

Clots: Yes/No PMS: Yes/No Regular Cycle: Yes/No Current Birth Control Use: Yes/No Past use: Yes/No Type(s)_____

Number of Pregnancies:_____ Number Live Children:_____ Perimenopausal Symptoms: _____

MENOPAUSAL WOMEN: Last period date:_____ Age at Menopause: _____ Postmenopausal Bleeding: Yes/No

CHECK ANY OF THESE SYMPTOMS YOU ARE EXPERIENCING: ( ) Hot flashes ( ) Night Sweats ( ) Fatigue ( ) Mood Swings ( ) Sleep Problems ( ) Dry Skin ( ) Vaginal Dryness ( ) Hair Loss ( ) Low Libido ( ) Painful Sex

Past or Present Hormone Replacement Therapy:

_____

_____

Provider Notes:

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BALANCE REGENERATIVE MEDICINE

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