

FEMALE HEALTH HISTORY & SYMPTOMS

For CDSS Continuous Round

PATIENT INFORMATION

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Weight: _____ Height: _____

PATIENT QUESTIONS

Have you been diagnosed with any cancer since initial pelleting (excluding basal cell carcinoma)?	Yes	No		
Blood clot, DVT, heart attack or stroke since being pelleted?	Yes	No		
Currently pregnant or trying to conceive?	Yes	No		
Had a recent mammogram (within last 12 months)?	Yes	No		
Have you had a hysterectomy since last insertion?	Yes	No		
If so, type of hysterectomy:	Complete (uterus and ovaries removed)	Partial (uterus only removed)		
Had menstrual cycle (within last 12 months)?	Yes	No		
Had endometrial ablation?	Yes	No		
Have you had any spotting or bleeding since last pellet?	Yes	No		
Are you on birth control?	Yes	No		
Name of birth control: _____				
Select types of hormones you are currently on:	Testosterone	Estrogen	Progesterone	Thyroid
Are you currently on statins?	Yes	No		
Are you a smoker?	Yes	No		
Are you currently on oral nitrates?	Yes	No		

PATIENT'S CURRENT AND PAST MEDICAL HISTORY

Select all that apply:

Cardiovascular Conditions:

Tachycardia
Hypertension
Hyperlipidemia
Obstructive Sleep Apnea
Atrial Fibrillation

Neurological Conditions:

Epilepsy or Seizure Disorder
Depression/Anxiety
Psychiatric Conditions
Migraine with Aura
Meningioma (since last pellet)

Gynecological Conditions:

Pre-Menstrual Syndrome
Endometriosis
Fibrocystic Breast Disease
Fibroids (since last pellet)
Polyps (since last pellet)

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MEDICAL HISTORY

Endocrine and Metabolic:

PCOS
Diabetes Type 2 or Insulin Resistance
Hyperthyroid
Hypothyroid
Multiple Endocrine Neoplasia Type-2

Autoimmune Conditions:

Diabetes Type 1
Hashimoto's Thyroiditis
Graves' Disease
Rheumatoid Arthritis
Multiple Sclerosis
Systemic Lupus (Erythematosus)
Psoriasis
IBS (Irritable Bowel Syndrome)
Crohn's Disease
Ulcerative Colitis

Organ Specific Conditions:

Liver Disease (since last pellet)
Kidney Disease (since last pellet)
LAM (Lymphangioleiomyomatosis)
Osteoporosis or Osteopenia
HIV
Hepatitis
Hemochromatosis
Pancreatitis (since last pellet)
History of or Gall Bladder Disease
Polycythemia Vera (PV)

SYMPTOMS AND CONCERNS

Select all that apply:

Hot Flashes	Cold Hands or Feet
Night Sweats	Brittle Nails
Vaginal Dryness	Dry or Flaking Skin
Decreased Interest in Sex	Lack of Energy (Fatigue)
Inability To or Delayed Orgasm	Decreased Muscle Mass
Painful Intercourse	Acne
Urinary Incontinence	Facial Hair
Frequent Urinary Tract Infection	Dry Eyes
Breast Tenderness	Joint Pain
Weight Gain	Difficulty Sleeping
Hair Loss	Mind Racing at Bedtime
Hair Thinning	Eating When Stressed
Thinning Eyebrows	