TRILOGY
HEALTH & WELLNESS CENTER

510 Swanson Road Tyrone, GA 30290

Name: _____ Date of birth: _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	None (0)	Mild (1)	Moderate (2)	Severe (3)	Very severe (4)
Hot flashes	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	☐	☐	☐	☐	☐
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory	☐	☐	☐	☐	☐
Problems with thinking, concentrating or reasoning	☐	☐	☐	☐	☐
Difficulty learning new things	☐	☐	☐	☐	☐
Trouble thinking of the right word to describe persons, places or things when speaking	☐	☐	☐	☐	☐
Increase in frequency or intensity of headaches or migraines	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feel cold all the time or have cold hands or feet	☐	☐	☐	☐	☐
Weight gain or difficulty losing weight despite diet and exercise	☐	☐	☐	☐	☐
Dry or wrinkled skin	☐	☐	☐	☐	☐
Total score	0				

Severity score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80

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FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of birth: _____ Age: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work: _____

Preferred contact number: _____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email address: _____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____
Address / City / State / Zip

Marital status (check one): ☐ Married ☐ Divorced ☐ Widow ☐ Living with partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work: _____

Social:

☐ I am sexually active.	OR	☐ I want to be sexually active.	☐ I do not want to be sexually active.
☐ I have completed my family.	OR	☐ I have NOT completed my family.	
☐ My sex life has suffered.	OR	☐ I have not been able to have an orgasm or it is very difficult.	

Habits:

☐ I smoke cigarettes or cigars_____per day. ☐ I use e-cigarettes_____a day. ☐ I use caffeine_____a day.

☐ I drink alcoholic beverages_____per week. ☐ I drink more than 10 alcoholic beverages a week.

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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Drug allergies

Drug allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No Do you have a latex allergy? ☐ Yes ☐ No

Medications currently taking: _____

Current hormone replacement? ☐ Yes ☐ No If yes, what? _____

Past hormone replacement therapy: _____

Family history:

☐ Heart disease ☐ Diabetes ☐ Osteoporosis ☐ Alzheimer's/dementia ☐ Breast cancer ☐ Other_____

Pertinent medical/surgical history:

- ☐ Breast cancer
- ☐ Uterine cancer
- ☐ Ovarian cancer
- ☐ Polycystic ovaries/PCOS
- ☐ Acne
- ☐ Excess facial/body hair
- ☐ Infertility
- ☐ Endometriosis
- ☐ Epilepsy or seizures
- ☐ Fibrocystic breast or breast pain
- ☐ Uterine fibroids
- ☐ Irregular or heavy periods
- ☐ Menstrual migraines
- ☐ Hysterectomy with removal of ovaries
- ☐ Partial hysterectomy (uterus only)
- ☐ Ophorectomy removal of ovaries only

Birth control method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal ligation
- ☐ Birth control pills
- ☐ Vasectomy
- ☐ IUD
- ☐ Infertility
- ☐ Other _____

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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical history:

- ☐ High blood pressure or hypertension
- ☐ Heart disease
- ☐ Atrial fibrillation or other arrhythmia
- ☐ Blood clot and/or a pulmonary embolism
- ☐ Depression/anxiety
- ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- ☐ Arthritis
- ☐ Hair thinning
- ☐ Sleep apnea
- ☐ High cholesterol
- ☐ Stroke and/or heart attack
- ☐ HIV or any type of hepatitis
- ☐ Hemochromatosis
- ☐ Psychiatric disorder
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Lupus or other autoimmune disease
- ☐ Other _____