PAGDIN HEALTH
LIVING LONGER BETTER
Dr. Grant Pagdin, MD
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Female General Health Questionnaire

Name: ____________________________________ Date: _________________________

Primary concern: ____

Symptom	How long have you been experiencing this?	None	Mild	Moderate	Severe
Dry Skin		☐	☐	☐	☐
Dry Hair		☐	☐	☐	☐
Cold Extremities		☐	☐	☐	☐
Insomnia		☐	☐	☐	☐
Excessive Sleep		☐	☐	☐	☐
Low Energy/Fatigue		☐	☐	☐	☐
Memory Loss		☐	☐	☐	☐
Poor Concentration		☐	☐	☐	☐
Mood Swings		☐	☐	☐	☐
Anxiety/Nervousness		☐	☐	☐	☐
Headaches		☐	☐	☐	☐
Depression/Sadness/Guilt		☐	☐	☐	☐
Decreased Sex Drive		☐	☐	☐	☐
Hot Flashes		☐	☐	☐	☐
Night Sweats		☐	☐	☐	☐
Muscle Pain/Weakness		☐	☐	☐	☐
Breast Tenderness		☐	☐	☐	☐
Abdominal Weight Gain		☐	☐	☐	☐
Heart Palpitations		☐	☐	☐	☐
Poor Bladder Control		☐	☐	☐	☐
Cramps/Spasms in Legs or Feet		☐	☐	☐	☐
Constipation		☐	☐	☐	☐
Diarrhea		☐	☐	☐	☐
Hair Loss		☐	☐	☐	☐
Thinning Eyebrows		☐	☐	☐	☐
Vaginal Dryness		☐	☐	☐	☐
Painful Intercourse		☐	☐	☐	☐
Heavy Periods		☐	☐	☐	☐
Irregular Periods		☐	☐	☐	☐

Are you experiencing any other symptoms not listed above? If yes, please explain:

____

____

____

Feminine Wellness

- □ Do you feel "loose" vaginally since childbirth and/or menopause?
- □ Do you feel dry during intercourse?
- □ Do you have trouble reaching orgasm?
- □ Do you occasionally dribble or leak when you sneeze, cough or exercise?
- □ Have you ever "not quite made it" to the bathroom on time?
- □ Are you experiencing a loss in self-confidence? Loss of interest in sex?

Past Hormone Medications

Please list any prescription or non-prescription medications you have taken to treat hormonal symptoms:

Name and dosage (if known)	Duration of use and approximate time frame	Was it effective? (Yes or No)

Current Medications

Please list all current non-hormonal medications that you are taking:

Name and dosage (if known)	Duration of use and approximate time frame	Was it effective? (Yes or No)

Current Supplements

Please list all current supplements that you are taking:

Name and dosage (if known)	Duration of use and approximate time frame	Was it effective? (Yes or No)

Current Allergies

Please list all any drug and non-drug allergies you have:

____

____

Lifestyle

What is your marital status? ____

What are your living arrangements? ☐ Live alone ☐ Live with partner

☐ Live with dependent children at home

☐ Dependent on other: ____________________________________

Do you smoke? ☐ No, never have ☐ No, quit at the age of _________, started at age _________

☐ Yes, how often? __________________________ How long have you smoked? ________

How often do you drink alcohol? ____________________________ Alcohol type(s): ______________________

How often do you exercise? ______________________________ Type(s) of exercise: __________________

Do you abide by a special diet? ☐ No ☐ Yes If yes, what type? (Vegan, Celiac, etc.)

____

Past Medical History

- ☐ Heart Disease/Heart Attack
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ Diabetes
- ☐ Thyroid Disease (Grave's/Hashimoto's/Hypo/Hyper/Unknown)
- ☐ Deep Vein Blood Clots
- ☐ Rheumatoid Arthritis or Other Arthritis
- ☐ Endometriosis
- ☐ Polycystic Ovaries
- ☐ Uterine Fibroids
- ☐ Breast Cancer
- ☐ Other: ____
- ☐ Stomach Ulcers
- ☐ Hysterectomy
- ☐ Benign Breast Lump
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Migraine Headaches
- ☐ Asthma/COPD
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's or Ulcerative Colitis
- ☐ Celiac Disease

Gynecologic and Obstetrical History

Age of first period: ________________ Date of last period: ___________________

Typical cycle and period length: (ex: 28 day cycle and 5 day period: __________________________________

Number of pregnancies: ________________ Number of births: ____________________

Last PAP test date: ________________ Any abnormal PAP test results? ☐ Yes ☐ No

Last mammogram date: ___________________ Any abnormal mammogram results? ☐ Yes ☐ No

Surgical History

List any past surgeries:	Date of surgery:
___________________________________	________________________________
___________________________________	________________________________
___________________________________	________________________________
___________________________________	________________________________
___________________________________	________________________________

Family History

Illness	Family Member(s)
Heart Attack	
Stroke	
Diabetes	
Colon Cancer	
Prostate Cancer	
Other Cancer:	
Osteoporosis	
Rheumatoid Arthritis	
Lupus	
Celiac Disease	
Depression / Anxiety	
Bipolar Disorder	
Schizophrenia	
Thyroid Problem	
Other:	

Please fax completed forms to **(250) 717-3220** or scan to email to info@pagdinhealth.com

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