Female Questionnaire

Name **Date**

INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints. Leave the question blank if it does not apply to you.
0 = RARELY OR NEVER EXPERIENCE SYMPTOM 1 = MILD 2 = MODERATE 3 = SEVERE

PART 1: For Females Only

Section A: Do you have any of these symptoms during menstruation?

1	Lower abdominal pain	0 1 2 3
2	Backache	0 1 2 3
3	Pinching/pain sensations in inner thigh	0 1 2 3
4	Intense cramps right before period	0 1 2 3
5	Bloating of your abdomen	0 1 2 3
6	Sugar craving	0 1 2 3
7	Light or heavy blood flow	0 1 2 3
8	Anxious about getting your period	0 1 2 3
9	Pain during period is getting worse	0 1 2 3
10	Stay in bed the first few days of period (Press 0 for NO, 1 for YES)	NO YES

Section B:

1	Vaginal itching or abnormal discharge	0 1 2 3
2	Low sex drive	0 1 2 3
3	Regularly do strenuous exercise	0 1 2 3
4	15 years or older and haven't gotten your period (Press 0 for NO, 1 for YES)	NO YES
5	Diagnosed or believe you have anorexia (Press 0 for NO, 1 for YES)	NO YES
6	Unable to get pregnant (Press 0 for NO, 1 for YES)	NO YES
7	Are you 5-10 lbs. under your ideal weight? (Press 0 for NO, 1 for YES)	NO YES
8	Have you had any miscarriages? (Press 0 for NO, 1 for YES)	NO YES
9	Have you had any abortions? (Press 0 for NO, 1 for YES)	NO YES
10	Lack of menstruation (Press 0 for NO, 1 for YES)	NO YES
11	Irregular periods (Press 0 for NO, 1 for YES)	NO YES

Section C: Do you have any of these symptoms prior to menstruation?

1	Depressed	0 1 2 3
2	Altered sex drive	0 1 2 3
3	Breast pain	0 1 2 3
4	Backache	0 1 2 3
5	Abdominal bloating	0 1 2 3
6	Swelling in hands and feet	0 1 2 3
7	Anxiety and/or suicidal feelings	0 1 2 3
8	Easily irritated and/or mood swings	0 1 2 3
9	Cramps	0 1 2 3
10	Crying for no apparent reason	0 1 2 3
11	Sugar craving	0 1 2 3
12	Headaches	0 1 2 3
13	Binge eating/crave certain foods	0 1 2 3
14	Insomnia	0 1 2 3
15	Weight gain each month (Press 0 for NO, 1 for YES)	NO YES

Section D:

1	Breast pain and tenderness	0 1 2 3
2	Breast swelling/tender to touch	0 1 2 3
3	Painful ovaries	0 1 2 3
4	Lower abdominal pain	0 1 2 3
5	Small lumps in your breast (Press 0 for NO, 1 for YES)	NO YES
6	History of breast cancer in your family (Press 0 for NO, 1 for YES)	NO YES
7	Have you ever been pregnant? (Press 0 for NO, 1 for YES)	NO YES
8	Recent pap smear test positive (Press 0 for NO, 1 for YES)	NO YES
9	Do you have ovarian or uterine cysts? (Press 0 for NO, 1 for YES)	NO YES
10	Do you have endometriosis? (Press 0 for NO, 1 for YES)	NO YES
11	Mother used D.E.S. (hormones) while pregnant with you (Press 0 for NO, 1 for YES)	NO YES
12	Sudden onset of pain on one side of abdomen half way between monthly cycles (Press 0 for NO, 1 for YES)	NO YES

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Section E:

1	Hot flashes	0 1 2 3
2	Weight gain	0 1 2 3
3	Memory Loss	0 1 2 3
4	Irritability/mood swings	0 1 2 3
5	Depression	0 1 2 3
6	Vaginal dryness and pain	0 1 2 3
7	Anxiety (sometimes followed by chills)	0 1 2 3
8	Low sex drive/low arousal time	0 1 2 3
9	Heart palpitations	0 1 2 3
10	Water retention	0 1 2 3
11	Night sweats and/or sweat throughout day	0 1 2 3
12	Above symptoms and over age 45 (Press 0 for NO, 1 for YES)	NO YES
13	Have you had a hysterectomy? (Press 0 for NO, 1 for YES)	NO YES
14	Diagnosed with osteoporosis (Press 0 for NO, 1 for YES)	NO YES
15	Irregular menstrual cycles or cycles have ceased (Press 0 for NO, 1 for YES)	NO YES