

HEALTH ASSESSMENT (FEMALE)



FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

| SYMPTOMS | NONE | MILD | MODERATE | SEVERE | VERY SEVERE |
|--------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Physical Exhaustion (fatigue, lack of energy, stamina or motivation) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep Problems (difficulty falling asleep or sleeping through the night) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritability (mood swings, feeling aggressive, angers easily) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Decline in drive or interest (loss of "zest for life," feeling down or sad) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulties with memory (concentration, finding the right word, or retaining information) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal dryness or difficulty with sexual intercourse | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sexual Problems (change in desire, activity, orgasm and/or satisfaction) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweating (night sweats or increased episodes of sweating) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hot Flashes (burst that starts in chest and lasts for short duration) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hair loss, thinning or change in texture of hair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling cold all the time, having cold hands or feet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches or migraines (increase in frequency or intensity) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight (difficulty losing weight despite diet/exercise) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder problems (difficulty in urinating, increased need to urinate, incontinence) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other symptoms or unique health circumstances to take into consideration:
