NEWPORT LONGEVITY MEDICAL GROUP, INC.

Female Hormone Questionnaire *

Please complete if requested by the staff and bring to your next scheduled appointment or fax to: (949) 721-9121.

Pre-menopausal and Peri-menopausal Women:

1. Do you experience frequent or irregular periods/menstruation?	Yes	No
2. Do you experience severe abdominal cramping with your periods?	Yes	No
3. Do you get breast tenderness around the time of your period?	Yes	No
4. Do you get moody or irritable right before or during your period?	Yes	No
5. Do you get heavy periods (heavy bleeding for more than 2-3 days)?	Yes	No
6. Do you have or have you had uterine fibroids?	Yes	No
7. Do you have trouble getting to sleep because your mind is racing?	Yes	No
8. Have you ever had trouble getting pregnant?	Yes	No
9. Have you ever had a miscarriage?	Yes	No
10. Do you get panic or anxiety attacks?	Yes	No
11. Do you take or have you taken birth control pills in the past two years?	Yes	No
12. Have you gone without a period for more than three months?	Yes	No
13. Have you ever experienced depression or post partum depression?	Yes	No
14. Do you get headaches or migraines around the time of your period?	Yes	No
15. Do you get cravings for sugar, salt, fat, or chocolate?	Yes	No
16. Do you experience pain during intercourse?	Yes	No
17. Do you get bloating and water retention during or around your period?	Yes	No
18. Do you take birth control (pills, patches, or injections)?	Yes	No
19. Do you have a family history of breast, uterine, or ovarian cancer?	Yes	No
20. Do you have endometriosis?	Yes	No

Post Menopausal Women

1. Was your last menstrual period more than one year ago?	Yes	No
2. Do you get "hot flashes"?	Yes	No
3. Do you get severe sweating at night?	Yes	No
4. Do you have vaginal dryness?	Yes	No
5. Have you noticed any vaginal thinning?	Yes	No
6. Do you have a reduced libido?	Yes	No
7. Do you have trouble getting back to sleep because your mind is racing?	Yes	No
8. Do you experience panic or anxiety attacks?	Yes	No
9. Do you experience any pain during intercourse?	Yes	No
10. Do you take any hormone replacement (pills, creams, patches, etc.)?	Yes	No
11. Do you have a family history of breast, uterine, or ovarian cancer?	Yes	No
12. Have you had a hysterectomy?	Yes	No

*adapted from ARK