LIGHTHOUSE
YOGA & ACUPUNCTURE

FEMALE HEALTH QUESTIONNAIRE

Name _____ Age _____ Date _____

What age did you start your period? _____

Are you currently pregnant? Y/N _____ Are you trying to get pregnant? Y/N _____

How many days is your cycle? _____

Are you currently on birth control? Y/N _____ What type? _____

Do you have regular pap tests? Y/N _____ How often? _____

Do you or have you ever experienced any of the following? If so, please explain below.

- ☐ Irregular cycle
- ☐ Heavy flow
- ☐ Light flow
- ☐ Clots in menstrual blood
- ☐ Menstrual related moodiness
- ☐ Menstrual related breast tenderness
- ☐ Menstrual related bloating
- ☐ Bleeding between cycles
- ☐ Painful periods (Is pain before, during and/or after period? _____
- ☐ Low back pain
- ☐ Hot flashes
- ☐ Vaginal dryness
- ☐ Breast lumps/cysts
- ☐ Uterine fibroids
- ☐ PCOS
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Unusual vaginal discharge
- ☐ Frequent yeast infections
- ☐ Decreased libido
- ☐ Gynecological operations: ovaries, tubes, vagina, breast, other

Explain: _____

Do you have any concerns with your sexual function? _____

Total number of pregnancies _____

Number of children and their ages _____

Number of miscarriages _____

Number of abortions _____

Any complications? _____

Have you completed menopause? _____

Last menstrual period _____