HIRSUTISM
PATIENT QUESTIONNAIRE

1. When did your excess hair growth begin? _____

   _____

   _____

2. Has it increased rapidly or slowly? *(circle one)* RAPIDLY SLOWLY
3. Have you noticed increased hair growth in the following locations?

face ·····	*no*	*yes*
near nipples·····	*no*	*yes*
lower abdomen·····	*no*	*yes*
arms ·····	*no*	*yes*
legs ·····	*no*	*yes*
upper back·····	*no*	*yes*
shoulders·····	*no*	*yes*
middle of chest·····	*no*	*yes*
upper abdomen·····	*no*	*yes*

4. Is the hair on your scalp significantly thinner than it used to be? *(circle one)* YES NO
5. How many days between menstrual periods? _____
6. Is this a regular cycle for you? *(circle one)* YES NO
7. If no, when did irregularity begin? _____
8. How many days does your menstrual flow last? _____
9. If you have irregular periods or long menstrual flows, has this been evaluated by a gynecologist or other physicians? _____
10. Have you notice enlargement of your clitoris? *(circle one)* YES NO
11. Current weight _____
12. Most you ever weighed: _____ when? _____

    Least you ever weighed: _____ when? _____
13. Do you have high blood pressure? *(circle one)* YES NO
14. If yes, when was your high blood pressure first noted? _____
15. Do you feel extremely fatigued most of the time? *(circle one)* YES NO _____
16. Do you feel colder than other people most of the time *(circle one)* YES NO
17. Do you have diabetes? *(circle one)* YES NO
18. If yes, when was your diabetes first noted? _____
19. Has your voice deepened? *(circle one)* YES NO

20. Do you have any discharge from your nipples? *(circle one)* YES NO

21. List all medications you are using now or have used in the last 6 months for any reason?

_____	_____
_____	_____
_____	_____
_____	_____