



FEMALE HEALTH HISTORY & SYMPTOMS

For CDSS Round 2

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

PATIENT QUESTIONS

Have you been diagnosed with any cancer since initial pelleting (excluding basal cell carcinoma)?

Yes No

Blood clot, DVT, heart attack or stroke since being pelleted?

Yes No

Currently pregnant or trying to conceive?

Yes No

Had a recent mammogram (within last 12 months)?

Yes No

Have you had a hysterectomy since last insertion?

Yes No

If so, type of hysterectomy:

Complete (uterus and ovaries removed)

Partial (uterus only removed)

Had menstrual cycle (within last 12 months)?

Yes No

Had endometrial ablation?

Yes No

Have you had any spotting or bleeding since last pellet?

Yes No

Are you on birth control?

Yes No

Name of birth control: _____

Select types of hormones you are currently on:

Testosterone

Estrogen

Progesterone

Thyroid

Are you currently on statins?

Yes No

Are you a smoker?

Yes No

MEDICAL HISTORY SINCE BEING PELLETTED

Select all that apply:

Cardiovascular Conditions:

Tachycardia

Hypertension

Hyperlipidemia

Obstructive Sleep Apnea

Atrial Fibrillation

Neurological Conditions:

Epilepsy or Seizure Disorder

Depression/Anxiety

Psychological Conditions

Migraine with Aura

Meningioma (since last pellet)

Gynecological Conditions:

Pre-Menstrual Syndrome

Endometriosis

Fibrocystic Breast Disease

Fibroids (since last pellet)

Polyps (since last pellet)



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MEDICAL HISTORY

Endocrine and Metabolic:

PCOS
Diabetes Type 2 or Insulin Resistance
Hyperthyroid
Hypothyroid

Autoimmune Conditions:

Diabetes Type 1
Hashimoto's Thyroiditis
Graves' Disease
Rheumatoid Arthritis
Multiple Sclerosis
Systemic Lupus (Erythematosus)
Psoriasis
IBS (Irritable Bowel Syndrome)
Crohn's Disease
Ulcerative Colitis

Organ Specific Conditions:

Liver Disease (since last pellet)
Kidney Disease (since last pellet)
LAM (Lymphangioleiomyomatosis)
Osteoporosis or Osteopenia
HIV
Hepatitis
Hemochromatosis
Pancreatitis (since last pellet)
History of or Gall Bladder Disease
Polycythemia Vera (PV)

SYMPTOMS AND CONCERNS

Select all that apply:

Hot Flashes	Cold Hands or Feet
Night Sweats	Brittle Nails
Vaginal Dryness	Dry or Flaking Skin
Decreased Interest in Sex	Lack of Energy (Fatigue)
Inability To or Delayed Orgasm	Decreased Muscle Mass
Painful Intercourse	Acne
Urinary Incontinence	Facial Hair
Frequent Urinary Tract Infection	Dry Eyes
Breast Tenderness	Joint Pain
Weight Gain	Difficulty Sleeping
Hair Loss	Mind Racing at Bedtime
Hair Thinning	Eating When Stressed
Thinning Eyebrows	