Rosen Wellness
Consultation Assessment (Female Plus)

General Information:

Name: ____ Date:__________________

Age: ______ Height: ___' ___" Weight: _____ lbs. Blood Type _____________

Major complaint(s) in order of significance to you:

1. ___________________________________ 4. __________________________________

2. ___________________________________ 5. __________________________________

3. ___________________________________ 6. __________________________________

Female Anatomy / Reproductive Health *(to be completed by all women)*
Age at onset of first period: ______ Approximate date of onset: ________________

What are you using for contraception at the moment?____________________________________
Have you ever used *oral, injected, patch, or ring* hormone contraceptives, or used *Emergency Contraception ("the day after" pill)?* ☐ Yes ☐ No
From _______________to________________
Did you suffer from any side effects? ☐ Yes ☐ No
Explain: ____
Are you currently or have you ever used and IUD? ☐ Yes ☐ No
When? ____________________________ For how long? ________________________________
While under the use of any and all birth control methods, did you experience the following?
Y*east, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc. (Please circle and use extra space provided if explanation is needed)*
____
____
____

Are you currently, or have you ever used fertility treatment? ☐ Yes ☐ No
If yes, please explain.
____
____

Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc.? ☐ Yes ☐ No
If yes, what hormone(s), dosage and for how long? Please be specific with dates of use.
____
____

Do you have any history of abnormal Pap Tests? □ Yes □ No
If yes, please explain:
____
Please describe any treatment and/or medication for this:
____

Do you have any history of vaginal infections? □ Yes □ No
If yes, please describe:
____
Please describe any treatment and/or medication for this:
____

Do you have any history of the following conditions? (*Please circle appropriate answer)*
Ovarian Cysts, Fibrocystic Breasts, Polycystic Ovarian Syndrome (PCOS), Uterine Fibroids, Endometriosis, Lichen Sclerosis, Vulvodynia

Pregnancy History *(to be completed by all women, if applicable)*
Have you been pregnant before? □ Yes □ No
Please list the age(s) of your children:
____
Please explain important details/complications below:
Number of pregnancies: ______ ____
Number of live births: ______ ____
Number of miscarriages: ______ ____
How many weeks gestation at the time of miscarry? _____ Weeks
Number of premature births: ______ ____
Number of cesarean births: ______ ____
Number of stillbirths: ______ ____
Number of ectopic pregnancies: ______ ____

All menopausal women should now skip to the bottom section of page 3 labeled "Menopausal Women" and continue on with the remainder of this questionnaire.

Cycling History *(to be completed by all women who have not reached menopause)*
What was the first date of your last menstrual period (LMP)?
____
Have you ever had tubal ligation surgery? □ Yes □ No
If so, please list the date and specific details:
____

Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle?
□<20 days □20-30 days □30-40 days □40-50 days □>50 days

What is the length of days your menstruation typically lasts? _____________

Do you consider your cycle to be regular? □ Yes □ No □ Not Always
Details:

____

What is your typical menstrual flow like? □ Light □ Medium □ Heavy
Details:

____

During menstruation, do you pass blood clots? □ Yes □ No How often? ________________
How would you describe your cramping? □ None □ Mild □ Moderate □ Severe
At what point in your cycle?

____

Have you noticed any recent changes to your cycle? □ Yes □ No
If yes, explain: ____________________
Do you experience any unusual or excessive vaginal discharge throughout the month?
□ Yes □ No When? __________________________
Do you ever experience itching or odor in the vaginal area? □ Yes □ No
When? __________________________
Do you experience any breast tenderness? □ None □ Mild □ Moderate □ Severe
If yes, at what point in your cycle?

____

Do you have nipple discharge at any point in your cycle? □ Yes □ No
If yes, at what point in your cycle? _________________________
Color? ___________________

End of survey for cycling women

Menopausal Women
What age were you at the onset of menopause? _________ Year of onset? ________
Date of your last menstrual period? ________________
Please describe any recent changes and/or symptoms associated with your cycle prior to menopause:____
____
____
____

Please list any and all GYN surgeries: What was the reason for each surgery?

1. ____
2. ____
3. ____
4. ____
5. ____

Please give an in depth explanation of how you perceive your experience transitioning into menopause: *(for example, please list symptoms, emotional changes, thoughts, stressors, etc.)*

____
____
____

Are you currently, or have you ever used conventional hormone replacement (HRT)? ________
If yes, please list the name of the prescription:
____
What is/was the dosage? ________________________ For how long? ______________________

Are you currently, or have you ever used bio-identical hormone creams/gels/sublingual, troche, oral? ☐ Yes ☐ No
If yes, please list the name(s) of each product:
____
What is/was the dosage? ________________________ For how long? _____________________

Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? ☐ Yes ☐ No
If yes, please list the name(s) of each product:
____
What is/was the dosage? ________________________ For how long? _____________________

Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? For how long? _____________________
If yes, what?
____
Treatment:
____

Below please describe your cycle history.
Would you have described your menstruation as:
☐ Easy ☐ Uncomfortable ☐ Difficult ☐ Debilitating
What was your typical menstrual flow? ☐ Light ☐ Medium ☐ Heavy
When you were cycling would you describe your cycle as regular? ☐ Yes ☐ No
If no, please give explanation:
____
____

In the past, if you have ever received any type of "treatment" for any cycle issues would you please explain:
____
____
____