THE INSTITUTE OF
Natural Health
Achieving Wellness Naturally

Health Questionnaire

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314-293-8123 www.theinstituteofnaturalhealth.com

Welcome to The Institute of Natural Health!

We pride ourselves on being extremely thorough when it comes to your health. Therefore, be sure to complete the following Questionnaire or pages BEFORE arriving at your first appointment:

- **Fill out every page of this Questionnaire**

- **Please bring a list of all of the medications and/or supplements you are currently taking or have taken in the past 6 months:**
  - **Include name of drug or supplement, dosage, reason for taking**
  - **Ex. Lipitor, 20mg, high cholesterol**
  - **Ex. Vit D, 1000 IU, low Vit D level**

- **Please read and sign the 'Office Policies and Procedures' document (on the following pages)**

Office policies and procedures

-We value our patient's time and would like to ensure a sufficient amount of time with each patient. Therefore, please arrive 15 minutes prior to your scheduled appointment to allow for timely care and/or treatment.

-Please bring your previous labs, handouts, and recommendations to each visit. This allows for continuity of care.

-If you have any questions, concerns, or comments about your care, nutrition, or exercise program, feel free to contact the clinic at 314-293-8123, or by email at info@theinstituteofnaturalhealth.com.

What to expect:

- On your first visit, you will undergo a complete health history and consultation, a comprehensive head-to-toe physical, a complete neurological evaluation, and a myriad of other diagnostic testing.
- After your case is carefully reviewed by the doctors at the Institute of Natural Health, you will receive an explanation of your health history, physical, and laboratory findings. You will be presented with a treatment plan specifically designed for you.

Missed appointment policy:

- As a courtesy to other patients, please inform the office at least 48 hours prior to an appointment you will miss. If the office is not notified, penalties may be applied.

I have read and understand the Office Policies and Procedures of the

Institute of Natural Health.

Name:_____Signature:_____

Date: ___/___/_____

INH staff initials: _____

GENERAL INFORMATION

Name First Middle Last

_____

Date of Birth_____

Age _____

Gender _____

Primary Address Street_____Apt. #_____

City_____State_____Zip_____

Home Phone _____

Cell Phone _____

Email _____

Emergency Contact 1 Name _____Phone Number_____
Relationship _____Cell Number _____

Primary Care Physician
Name_____
Phone_____Fax_____

Referred By: ☐ Media ☐ Friend or Family Member
☐ Other _____

Allergies

Medication / Supplement / Food	Reaction

Complaints / Concerns

Please list current and ongoing problems in order of importance:

Describe Problem	Prior Treatment / Approach

When was the last time you felt well?_____

Did something trigger your change in health?_____

What makes you feel worse?_____

What makes you feel better?_____

What are your health objectives?

Physical History

Please list any broken bones or dislocations: _____

Please list any Motor Vehicle Accidents:

Hospitalizations and / or Surgeries

Date _____ Reason _____

_____ _____

_____ _____

Dental History

When was the last time you went to the dentist? _____

Dental Surgery

☐ Silver mercury fillings; How many?_____

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Medications

Current Medications

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Past Medication l*ast 10 years*

Medication	Dose	Frequency	Start Date (month/year)	Reason for Use

Nutritional Supplements (Vitamins/Minerals/Herbs/Homeopathy)

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason for Use

Have your medications or supplements ever cause you unusual side effects or problems? ☐ Yes ☐ No

Describe:_____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No
Frequent antibiotics >3 times/year? ☐ Yes ☐ No
Long term antibiotics? ☐ Yes ☐ No
Use of oral contraceptives? ☐ Yes ☐ No

Family History

Check Family Members that apply

	Mother	Father	Sibling	Sibling	Sibling	Sibling	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities, or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Social History

Have you ever made any changes in your eating habits because of your health? □ Yes □ No
Describe:_____
Do you currently follow a special diet or nutritional program? □ Yes □ No

Check all that apply:
□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic
□ No Dairy □ No Wheat □ Gluten Restricted □ Vegetarian □ Vegan
□
□ Specific Program for Weight Loss/Maintenance Type:_____
□ Other _____

Usual Weight Range +/- 5lbs_____ Desired Weight Range +/- 5lbs_____
Weight Fluctuations +/- 10lb? □ Yes □ No Body Fat %_____

If you could eat a few foods a week, what would they be?_____
_____
Do you cook? □ Yes □ No If no, who does the cooking?_____
How many meals do you eat out per week? □ 0-1 □ 1-3 □ 3-5 □ >5 meals per week

Currently Smoking? □ Yes □ No How many years?_____ Packs Per Day:_____
Attempts to quit:_____
Previous Smoking: How many years?_____Packs per day_____
Second hand smoke exposure?_____

How many drinks currently per week? *1 drink=5ounces wine, 12ounces beer, 1.5ounces spirits*
□ None □ 1-3 □ 4-6 □ 7-10 □ >10

Caffeine Intake: □ Yes □ No Coffee cups/day: □ 1 □ 2-4 □ >4 Tea cups/day: □ 1 □ 2-4 □ >4
Caffeinated Sodas or Diet Sodas Intake: □ Yes □ No
Are you currently using any recreational drugs? □ Yes □ No Type:_____
Have you ever used IV or inhaled recreational drugs: □ Yes □ No

Symptom Review

Please check all current symptoms occurring or present in the past 6 months

GENERAL
- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares

HEAD, EYES & EARS
- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Retinal Detachment

MUSCULOSKELETAL
- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightens
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- Muscle Twitches:
  - ☐ Around Eyes
  - ☐ Arms or Legs
- ☐ Muscle Weakness
- ☐ Neck Muscle Spasm
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- Difficulty:
  - ☐ With Balance
  - ☐ With Thinking
  - ☐ With Judgement
  - ☐ With Speech
  - ☐ With Memory
- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Nausea
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Cravings (bread, pasta)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION
- ☐ Anal spasms
- ☐ Bad Teeth
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Foods "Repeat" (Reflux)
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- Intolerance to:
  - ☐ Lactose
  - ☐ All Dairy Products
  - ☐ Wheat
  - ☐ Gluten (Wheat, Rye, Barley)
  - ☐ Corn
  - ☐ Eggs
  - ☐ Fatty Foods
  - ☐ Yeast
- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

CARDIOVASCULAR
- ☐ Angina/Chest Pain
- ☐ Breathlessness

SKIN PROBLEMS
□ Athlete's Foot
□ Bumps on Back of Upper Arms
□ Cellulite
□ Dark Circles Under Eyes
□ Ears Get Red
□ Easy Bruising
□ Lack of Sweating
□ Eczema
□ Hives
□ Jock Itch
□ Lackluster Skin
□ Moles with Color/Size Change
□ Oily Skin
□ Pale Skin
□ Patchy Dullness
□ Rash
□ Red Face
□ Sensitivity to Bites
□ Sensitivity to Poison Ivy/Oak
□ Shingles
□ Skin Darkening
□ Strong Body Odor
□ Hair Loss
□ Vitiligo

ITCHING SKIN
□ Skin in General
□ Anus
□ Arms
□ Ear Canals
□ Eyes
□ Feet
□ Hands
□ Legs
□ Nipples
□ Nose
□ Penis
□ Roof of Mouth
□ Scalp
□ Throat

SKIN, DRYNESS OF
□ Eyes
□ Feet
□ Any Cracking?
□ Any Peeling?
□ Hair
□ And Unmanageable?
□ Hands
□ Any Cracking
□ Any Peeling
□ Mouth/Throat
□ Scalp
□ Any Dandruff
□ Skin in General

LYMPH NODES
□ Enlarged/neck
□ Tender/neck
□ Other Enlarged/Tender
□ Lymph Nodes

NAILS
□ Brittle
□ Curve Up
□ Fungus-Fingers
□ Fungus-Toes
□ Pitting
□ Ragged Cuticles
□ Ridges
□ Soft
Thickening of:
□ Fingernails
□ Toenails
□ White Spots/Lines

RESPIRATORY
□ Bad Breath
□ Bad Odor in Nose
□ Cough-Dry
□ Cough-Productive
□ Hoarseness
□ Sore Throat
Hay Fever:
□ Spring
□ Summer
□ Fall
□ Change of Season
□ Nasal Stuffiness
□ Nose Bleeds
□ Post Nasal Drip
□ Sinus Fullness
□ Sinus Infection
□ Snoring
□ Wheezing
□ Winter Stuffiness
□ Heart Murmur
□ Irregular Pulse
□ Palpitations
□ Swollen Ankles/Feet
□ Varicose Veins

URINARY
□ Bed Wetting
□ Hesitancy (trouble getting started)
□ Infection
□ Kidney Disease
□ Leaking/Incontinence
□ Pain/Burning
□ Prostate Infection
□ Urgency

MALE REPRODUCTIVE
□ Ejaculation Problem
□ Genital Pain
□ Impotence
□ Prostate or Urinary Infection
□ Lumps in Testicles
□ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
□ Breast Cysts
□ Breast Lumps
□ Breast Tenderness
□ Ovarian Cyst
□ Vaginal Discharge
□ Vaginal Odor
Premenstrual:
□ Bloating Breast Tenderness
□ Carbohydrate Cravings
□ Chocolate Cravings
□ Constipation
□ Decreased Sleep
□ Diarrhea
□ Fatigue
□ Increased Sleep
□ Irritability
Menstrual:
□ Cramps
□ Heavy Periods
□ Irregular Periods
□ No Periods
□ Scanty Periods
□ Spotting Between

Metabolic Assessment

Please mark the appropriate number 0-3 on all questions
0 as the least/never to 3 as the most/always

Category 1

Feeling that bowels do not empty completely	☐ 0	☐ 1	☐ 2	☐ 3
Lower abdominal pain relief by passing gas or stool	☐ 0	☐ 1	☐ 2	☐ 3
Alternating constipation and diarrhea	☐ 0	☐ 1	☐ 2	☐ 3
Diarrhea	☐ 0	☐ 1	☐ 2	☐ 3
Constipation	☐ 0	☐ 1	☐ 2	☐ 3
Hard, dry, or small stool	☐ 0	☐ 1	☐ 2	☐ 3
Coated tongue of "fuzzy" debris on tongue	☐ 0	☐ 1	☐ 2	☐ 3
Pass large amount of foul smelling gas	☐ 0	☐ 1	☐ 2	☐ 3
More than 3 bowel movements daily	☐ 0	☐ 1	☐ 2	☐ 3
Use laxatives frequently	☐ 0	☐ 1	☐ 2	☐ 3

Category 2

Excessive belching, burping, or bloating	☐ 0	☐ 1	☐ 2	☐ 3
Gas immediately following a meal	☐ 0	☐ 1	☐ 2	☐ 3
Offensive breath	☐ 0	☐ 1	☐ 2	☐ 3
Difficult bowel movements	☐ 0	☐ 1	☐ 2	☐ 3
Sense of fullness during and after meals	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty digesting fruits and vegetables; Undigested foods found in stools	☐ 0	☐ 1	☐ 2	☐ 3

Category 3

Stomach pain, burning, or aching 1-4 hours after eating	☐ 0	☐ 1	☐ 2	☐ 3
Do you frequently use antacids?	☐ 0	☐ 1	☐ 2	☐ 3
Feeling hungry an hour or two after eating	☐ 0	☐ 1	☐ 2	☐ 3
Heartburn when lying down or bending forward	☐ 0	☐ 1	☐ 2	☐ 3
Temporary relief from antacids, food, milk, carbonated beverages	☐ 0	☐ 1	☐ 2	☐ 3
Digestive problems subside with rest and relaxation	☐ 0	☐ 1	☐ 2	☐ 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	☐ 0	☐ 1	☐ 2	☐ 3

Category 4

Roughage and fiber cause constipation	☐ 0	☐ 1	☐ 2	☐ 3
Indigestion and fullness last 2-4 hours after eating	☐ 0	☐ 1	☐ 2	☐ 3
Pain, tenderness, soreness on left side under rib cage	☐ 0	☐ 1	☐ 2	☐ 3
Excessive passage of gas	☐ 0	☐ 1	☐ 2	☐ 3
Nausea and/or vomiting	☐ 0	☐ 1	☐ 2	☐ 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	☐ 0	☐ 1	☐ 2	☐ 3
Frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
Increased thirst and appetite	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty losing weight	☐ 0	☐ 1	☐ 2	☐ 3

Category 5

Greasy or high fat foods cause distress	☐ 0	☐ 1	☐ 2	☐ 3
Lower bowel gas and/or bloating several hours after eating	☐ 0	☐ 1	☐ 2	☐ 3
Bitter metallic taste in mouth, especially in the morning	☐ 0	☐ 1	☐ 2	☐ 3
Unexplained itchy skin	☐ 0	☐ 1	☐ 2	☐ 3
Yellowish cast to eyes	☐ 0	☐ 1	☐ 2	☐ 3
Stool color alternates from clay colored to normal brown	☐ 0	☐ 1	☐ 2	☐ 3
Reddened skin, especially palms	☐ 0	☐ 1	☐ 2	☐ 3
Dry or flaky skin and/or hair	☐ 0	☐ 1	☐ 2	☐ 3
History of gallbladder attacks or stones	☐ 0	☐ 1	☐ 2	☐ 3
Have you had your gallbladder removed	☐ Yes	☐ No		

Category 6

Crave sweets during the day	☐ 0	☐ 1	☐ 2	☐ 3
Irritable if meals are missing	☐ 0	☐ 1	☐ 2	☐ 3
Depend on coffee to get yourself going or started	☐ 0	☐ 1	☐ 2	☐ 3
Get lightheaded if meals are missing	☐ 0	☐ 1	☐ 2	☐ 3
Eating relieves fatigue	☐ 0	☐ 1	☐ 2	☐ 3
Feel shaky, jittery, tremors	☐ 0	☐ 1	☐ 2	☐ 3
Agitated, easily upset, nervous	☐ 0	☐ 1	☐ 2	☐ 3
Poor memory, forgetful	☐ 0	☐ 1	☐ 2	☐ 3
Blurred vision	☐ 0	☐ 1	☐ 2	☐ 3

Category 7

Fatigue after meals	☐ 0	☐ 1	☐ 2	☐ 3
Crave sweets during the day	☐ 0	☐ 1	☐ 2	☐ 3
Eating sweets does not relieve cravings for sugar	☐ 0	☐ 1	☐ 2	☐ 3
Must have sweets after meals	☐ 0	☐ 1	☐ 2	☐ 3
Waist girth is equal or larger than hip girth	☐ 0	☐ 1	☐ 2	☐ 3
Frequent urination	☐ 0	☐ 1	☐ 2	☐ 3
Increased thirst & appetite	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty in losing weight	☐ 0	☐ 1	☐ 2	☐ 3

Category 8

Cannot stay asleep	☐ 0	☐ 1	☐ 2	☐ 3
Crave salt	☐ 0	☐ 1	☐ 2	☐ 3
Slow starter in the morning	☐ 0	☐ 1	☐ 2	☐ 3
Afternoon fatigue	☐ 0	☐ 1	☐ 2	☐ 3
Dizziness when standing up quickly	☐ 0	☐ 1	☐ 2	☐ 3
Afternoon headaches	☐ 0	☐ 1	☐ 2	☐ 3
Headaches with exertion or stress	☐ 0	☐ 1	☐ 2	☐ 3
Weak nails	☐ 0	☐ 1	☐ 2	☐ 3

Category 9

Cannot fall asleep	☐ 0	☐ 1	☐ 2	☐ 3
Perspire easily	☐ 0	☐ 1	☐ 2	☐ 3
Under high amounts of stress	☐ 0	☐ 1	☐ 2	☐ 3
Weight gain when under stress	☐ 0	☐ 1	☐ 2	☐ 3
Wake up tired even after 6 or more hours of sleep	☐ 0	☐ 1	☐ 2	☐ 3
Excessive perspiration with little or no activity	☐ 0	☐ 1	☐ 2	☐ 3

Category 10

Tired, sluggish	☐ 0	☐ 1	☐ 2	☐ 3
Feel cold – hands, feet, all over	☐ 0	☐ 1	☐ 2	☐ 3
Require excessive amounts of sleep to function properly	☐ 0	☐ 1	☐ 2	☐ 3
Increase in weight gain even with low-calorie diet	☐ 0	☐ 1	☐ 2	☐ 3
Gain weight easily	☐ 0	☐ 1	☐ 2	☐ 3
Difficult, infrequent bowel movements	☐ 0	☐ 1	☐ 2	☐ 3
Depression, lack of motivation	☐ 0	☐ 1	☐ 2	☐ 3
Morning headaches that wear off as the day progresses	☐ 0	☐ 1	☐ 2	☐ 3
Outer third of eyebrow thins	☐ 0	☐ 1	☐ 2	☐ 3
Thinning of hair on scalp, face, or genitals or excessive falling hair	☐ 0	☐ 1	☐ 2	☐ 3
Dryness of skin and/or scalp	☐ 0	☐ 1	☐ 2	☐ 3
Mental sluggishness	☐ 0	☐ 1	☐ 2	☐ 3

Category 11

Heart palpitations	☐ 0	☐ 1	☐ 2	☐ 3
Inward trembling	☐ 0	☐ 1	☐ 2	☐ 3
Increased pulse even at rest	☐ 0	☐ 1	☐ 2	☐ 3
Nervous and emotional	☐ 0	☐ 1	☐ 2	☐ 3
Insomnia	☐ 0	☐ 1	☐ 2	☐ 3
Night sweats	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty gaining weight	☐ 0	☐ 1	☐ 2	☐ 3

Category 12

Diminished sex drive	☐ 0	☐ 1	☐ 2	☐ 3
Menstrual disorders or lack of menstruation	☐ 0	☐ 1	☐ 2	☐ 3
Increased ability to eat sugars without symptoms	☐ 0	☐ 1	☐ 2	☐ 3

Category 13

Increased sex drive	☐ 0	☐ 1	☐ 2	☐ 3
Tolerance to sugars reduced	☐ 0	☐ 1	☐ 2	☐ 3
“Splitting” type headaches	☐ 0	☐ 1	☐ 2	☐ 3

Category 14

Urination difficulty or dribbling	☐ 0	☐ 1	☐ 2	☐ 3
Urination frequent	☐ 0	☐ 1	☐ 2	☐ 3
Pain inside of legs or heels	☐ 0	☐ 1	☐ 2	☐ 3
Feeling of incomplete bowel excavation	☐ 0	☐ 1	☐ 2	☐ 3
Leg nervousness at night	☐ 0	☐ 1	☐ 2	☐ 3

Category 15

Decrease in libido	☐ 0	☐ 1	☐ 2	☐ 3
Decrease in spontaneous morning erections	☐ 0	☐ 1	☐ 2	☐ 3
Decrease in fullness of erections	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty in maintaining morning erections	☐ 0	☐ 1	☐ 2	☐ 3
Spells of mental fatigue	☐ 0	☐ 1	☐ 2	☐ 3
Inability to concentrate	☐ 0	☐ 1	☐ 2	☐ 3
Episodes of depression	☐ 0	☐ 1	☐ 2	☐ 3
Muscle soreness	☐ 0	☐ 1	☐ 2	☐ 3
Decrease in physical stamina	☐ 0	☐ 1	☐ 2	☐ 3
Unexplained weight gain	☐ 0	☐ 1	☐ 2	☐ 3
Increase in fat distribution around chest and thighs	☐ 0	☐ 1	☐ 2	☐ 3

Sweating attacks	□ 0	□ 1	□ 2	□ 3
More emotional than in the past	□ 0	□ 1	□ 2	□ 3

Category 16

Are you perimenopausal	□ Yes	□ No		
Alternating menstrual cycle lengths	□ Yes	□ No		
Extended menstrual cycle, greater than 32 days	□ Yes	□ No		
Shortened menses, less than every 24 days	□ Yes	□ No		
Pain and cramping during periods	□ 0	□ 1	□ 2	□ 3
Scanty blood flow	□ 0	□ 1	□ 2	□ 3
Heavy blood flow	□ 0	□ 1	□ 2	□ 3
Breast pain and swelling during menses	□ 0	□ 1	□ 2	□ 3
Pelvic pain during menses	□ 0	□ 1	□ 2	□ 3
Irritable and depressed during menses	□ 0	□ 1	□ 2	□ 3
Acne breaks out	□ 0	□ 1	□ 2	□ 3
Facial hair growth	□ 0	□ 1	□ 2	□ 3
Hair loss/thinning	□ 0	□ 1	□ 2	□ 3

Category 17

How many years have you been menopausal	_____			
Since menopause, do you ever have uterine bleeding?	□ Yes	□ No		
Hot flashes	□ 0	□ 1	□ 2	□ 3
Mental fogginess	□ 0	□ 1	□ 2	□ 3
Disinterest in sex	□ 0	□ 1	□ 2	□ 3
Mood swings	□ 0	□ 1	□ 2	□ 3
Depression	□ 0	□ 1	□ 2	□ 3
Painful intercourse	□ 0	□ 1	□ 2	□ 3
Shrinking breasts	□ 0	□ 1	□ 2	□ 3
Facial hair growth	□ 0	□ 1	□ 2	□ 3
Acne	□ 0	□ 1	□ 2	□ 3
Increased vaginal pain, dryness or itching	□ 0	□ 1	□ 2	□ 3

Group A

O *Your life seems incomplete.*
O *You feel shy with all but your closest friends.*
O *You have feelings of insecurity.*
O *You often feel unequal to others.*
O *When things go right, you may feel undeserving.*
O *You feel something is missing in your life.*
O *You occasionally feel a low self-worth or self-esteem.*
O *You feel inadequate as a person.*
O *You frequently feel fearful when there is nothing to fear.*

Group B

O *You often feel anxious for no reason.*
O *You sometimes feel "free-floating" anxiety.*
O *You frequently feel "edgy," and it's difficult to relax.*
O *You often feel a "knot" in your stomach.*
O *Falling asleep is sometimes difficult.*
O *It's hard to turn your mind off when you want to relax.*
O *You occasionally experience feelings of panic for no reason.*
O *You often use alcohol or other sedatives to calm down.*

Group C

O *You lack pleasure in life.*
O *You feel there are no real rewards in life.*
O *You have unexplained lack of concern for others, even loved ones.*
O *You experience decreased parental feelings.*
O *Life seems less "colorful" or "flavorful."*
O *Things that used to be "fun" aren't any longer enjoyable.*
O *You have become a less spiritual or socially concerned person.*

Group D

O *You suffer from a lack of energy.*
O *You often find it difficult to "get going."*
O *You suffer from decreased drive.*
O *You often start projects and don't finish them.*
O *You frequently feel a need to sleep or "hibernate."*
O *You feel depressed a good deal of the time.*
O *You occasionally feel paranoid.*
O *Your survival seems threatened.*
O *You are bored a great deal of the time.*

Group E

O *It's hard to go to sleep.*
O *You can't stay asleep.*
O *You often feel irritable.*
O *Your emotions often lack rationality.*
O *You occasionally experience unexplained tears.*
O *Noise bothers you more than it used to; it seems louder than normal.*
O *You flare up at others more easily than you used to; you experience unprovoked anger.*
O *You feel depressed much of the time.*
O *You find you are more susceptible to pain.*
O *You prefer to be left alone.*