Myofascial Medicine & Natural Hormone Clinic
1014 Beaufort St, Bedford, WA 6052
Phone: 9471 8911 • Fax: 9471 8922

Questionnaire - Female

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Phone: (Home) _____ (Work) _____ (Mobile) _____

Address: _____

Email Address: _____

Height (cm): _____ Weight (kg): _____

GP Name: _____ Phone: _____

Address: _____

List the major symptoms you are currently experiencing:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you have any root canal fillings? Yes ☐ No ☐

Do you have any amalgam/mercury fillings? Yes ☐ No ☐

IMPORTANT: BODY TEMPERATURE MEASUREMENT.

If time permits, Please take your body temperature using an oral thermometer on 5 separate mornings and record below. Do the measurement just after waking (prior to any food or drink). They do not need to be on consecutive mornings.

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5

Current menstrual pattern (regular, irregular, heavy, light, etc.): _____

Menstrual period started at age: _____

Total number of pregnancies: _____ Number of live births: _____

Have you ever taken the oral contraception pill at any stage in your life? Yes ☐ No ☐

Note approximate periods of times in your life you took the oral contraceptive pill:

(e.g. Age 14-25, pregnancy, no oral contraceptive pill until next pregnancy age 30, oral contraceptive pill 32 until now)

_____

_____

Have you had a hysterectomy? No ☐ Yes ☐ Date: _____

Have your ovaries been removed? No ☐ Yes ☐ Date: _____

When was your last breast check by a doctor? _____

When was your last mammogram? _____

Result of last mammogram: _____

When was your last pap smear test? _____

Result of last pap smear test: _____

Have you had a bone densitometry to check for Osteoporosis? No ☐ Yes ☐ Date: _____

Result of last densitometry: _____

List any surgical operations you have had in your life:

_____

_____

_____

List any medical illnesses you have had in your life:

List any family history of illnesses, in particular breast cancer or blood clotting problems:

List any major stress events in your life (e.g. the death of someone close to you, divorce, etc):

What are your current work and life activities? (e.g. job, home activities, hobbies)

List any hormone replacement therapy you have had:

List any medications you are currently taking:

List any supplements you are currently taking:

List the things you do for exercise each week. (If your job is physically demanding include this too):

If you have been / are a current smoker please complete the following details

Began smoking: _____

Quit smoking between: _____ and _____

_____ and _____

_____ and _____

_____ and _____

Quit smoking successfully: _____

Still smoking? Please list the amount of cigarettes per day: _____

Fluid amounts per day

Coke / Pepsi / other caffeinated soft drinks: _____

Other soft drinks: _____

Milk: _____

Water: _____

Coffee: _____

Tea: _____

Alcohol: _____

Dietary History

State what are the most common things you would eat with each meal

Breakfast: _____

_____

Mid morning: _____

_____

Lunch: _____

_____

Mid afternoon: _____

_____

Dinner: _____

_____

After Dinner: _____

_____

Snacks: _____

_____

Shade in all areas of pain - include headaches and any other pain anywhere in the body