FUNCTIONAL MEDICINE HEALTH APPRAISAL

INNOVATIVEHealth
InnovativeHealthClinic.com
715-355-4224

NAME: _____ **DATE:** _____

Please use this questionnaire to assess how you've been feeling over the last four months. It covers many different areas and will enable us to have a complete picture of your health. Please take the time to answer all questions as best as you can. All information is held in strict confidence.

For each question, **circle the number that best describes your symptoms during the last four months.**

0 = No or Rarely—You have never experienced the symptom, or the symptom is familiar to you but you perceive it as insignificant (monthly or less).

1 = Occasionally—Symptom comes and goes and is linked in your mind to stress, diet, fatigue, or some identifiable trigger.

4 = Often—Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it.

8 = Frequently—Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis.

Some questions require a Yes or No response. Yes = 8, No = 0.

PART I

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
1. Indigestion, food repeats on you (taste comes back up) after you eat	0	1	4	8
2. Excessive burping, belching, and/or bloating following meals	0	1	4	8
3. Stomach spasms and cramping during or after eating	0	1	4	8
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure, and bloating during or after a meal	0	1	4	8
5. Bad taste in your mouth	0	1	4	8
6. Small amounts of food fill you up immediately	0	1	4	8
7. Skip meals or eat erratically because you have no appetite	0	1	4	8
Total points				
SECTION B				
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8
3. Stomach pain, burning, and/or aching over a period of 1-4 hours after eating	0	1	4	8
4. Stomach pain, burning, and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1	4	8
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8
6. Digestive problems that subside with rest & relaxation	No= 0		Yes= 8	
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus, or hot peppers causes your stomach to burn or ache	0	1	4	8
8. Feel a sense of nausea when you eat	0	1	4	8
9. Difficulty or pain when swallowing food or beverage	0	1	4	8
Total points				
SECTION C				
1. When massaging under your rib cage on your *left side*, there is pain, tenderness, or soreness	0	1	4	8
2. Indigestion, fullness, or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8
4. Specific foods/beverages aggravate indigestion	0	1	4	8
5. The consistency or form of your stool changes (e.g. from narrow to loose) within the course of a day	0	1	4	8
SECTION C *(cont'd)*				
6. Stool odor is embarrassing	0	1	4	8
7. Undigested food in your stool	0	1	4	8
8. Three or more large bowel movements daily	0	1	4	8
9. Diarrhea (frequent loose, watery stool)	0	1	4	8
10. Bowel movement shortly after eating (within 1 hour)	0	1	4	8
Total points				
SECTION D				
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps, or gas	0	1	4	8
3. Generally constipated (or straining during bowel movements)	0	1	4	8
4. Stool is small, hard, and dry	0	1	4	8
5. Pass mucus in your stool	0	1	4	8
6. Alternate between constipation and diarrhea	0	1	4	8
7. Rectal pain, itching, or cramping	0	1	4	8
8. No urge to have a bowel movement	No= 0		Yes= 8	
9. An almost continual need to have a bowel movement	No= 0		Yes= 8	
Total points				

PART II

1. When massaging under your rib cage on your *right side*, there is pain, tenderness, or soreness	0	1	4	8
2. Abdominal pain worsens with deep breathing	0	1	4	8
3. Pain at night that may move to your back or right shoulder	0	1	4	8
4. Bitter fluid repeats (comes back up) after eating	0	1	4	8
5. Feel abdominal discomfort or nausea when eating rich, fatty, or fried foods	0	1	4	8
6. Throbbing temples and/or dull pain in forehead associated with overeating	0	1	4	8
7. Unexplained itchy skin that's worse at night	0	1	4	8
8. Stool color alternates from clay colored to normal brown	0	1	4	8
9. General feeling of poor health	0	1	4	8

PART II
cont'd

	No/Rarely	Occasionally	Often	Frequently
10. Aching muscles not due to exercise	0	1	4	8
11. Retain fluid and feel swollen around the abdominal area	0	1	4	8
12. Reddened skin, especially palms	0	1	4	8
13. Very strong body odor	0	1	4	8
14. Are you embarrassed by your breath?	0	1	4	8
15. Bruise easily	No= 0		Yes= 8	
16. Yellowish cast to eyes	No= 0		Yes= 8	
Total points				

PART III

SECTION A

1. Feel cold or chilled—hands, feet, or all over—for no apparent reason	0	1	4	8
2. Your upper eyelids look swollen	0	1	4	8
3. Muscles are weak, cramp, and/or tremble	0	1	4	8
4. Are you forgetful?	0	1	4	8
5. Do you feel like your heart beats slowly?	0	1	4	8
6. Reaction time seems slowed down	0	1	4	8
7. In general, are you disinterested in sex because your desire is low?	0	1	4	8
8. Feel slow moving, sluggish	0	1	4	8
9. Constipation	0	1	4	8
10. Dryness, discoloration of skin and/or hair	No= 0		Yes= 8	
11. Have you noticed recently that your voice is deepening?	No= 0		Yes= 8	
12. Thick, brittle nails	No= 0		Yes= 8	
13. Weight gain for no apparent reason	No= 0		Yes= 8	
14. Outer third of your eyebrow is thinning or disappearing	No= 0		Yes= 8	
15. Swelling of the neck	No= 0		Yes= 8	
Total points				

SECTION B

1. Lingering mild fatigue after exertion or stress	0	1	4	8
2. Do you find that you get tired and exhaust easily?	0	1	4	8
3. Craving for salty foods	0	1	4	8
4. Sensitive to changes in weather and surroundings	0	1	4	8
5. Dizzy when rising or standing up from a kneeling position	0	1	4	8
6. Dark bluish or black circles under your eyes	0	1	4	8
7. Have bouts of nausea with or without vomiting	0	1	4	8
8. Catch colds or infections easily	No= 0		Yes= 8	
9. Wounds heal slowly	No= 0		Yes= 8	
10. Your body or parts of your body feel tender, sore, sensitive to the touch, hot, and/or painful	0	1	4	8
11. Feel puffy and swollen all over your body	0	1	4	8
12. Skin is gradually tanning without exposure to sun or without the ingestion of high levels of carotene-rich foods (e.g. daily carrot juice intake) or supplements	No= 0		Yes= 8	
Total points				

PART IV

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
When you miss meals or go without food for extended periods of time, do you experience any of the following symptoms?				
1. A sense of weakness	0	1	4	8
2. A sudden sense of anxiety when you get hungry	0	1	4	8
3. Tingling sensation in your hands	0	1	4	8
4. A sensation of your heart beating too quickly or forcefully	0	1	4	8
5. Shaky, jittery, hands trembling	0	1	4	8
6. Sudden profuse sweating and/or your skin feels clammy	0	1	4	8
7. Nightmares possibly associated with going to bed on an empty stomach	0	1	4	8
8. Wake up at night feeling restless	0	1	4	8
9. Agitation, easily upset, nervous	0	1	4	8
10. Poor memory, forgetful	0	1	4	8
11. Confused or disoriented	0	1	4	8
12. Dizzy, faint	0	1	4	8
13. Cold or numb	0	1	4	8
14. Mild headaches or head pounding	0	1	4	8
15. Blurred vision or double vision	0	1	4	8
16. Feel clumsy and uncoordinated	0	1	4	8
Total points				

SECTION B

1. Frequent urination during the day and night	0	1	4	8
2. Unusual thirst—feeling like you can't drink enough water	0	1	4	8
3. Unusual hunger—eating all the time	0	1	4	8
4. Vision blurs	0	1	4	8
5. Feel itchy all over	0	1	4	8
6. Tingling or numbness in your feet	0	1	4	8
7. Sense of drowsiness, lethargy during the day not associated with missing meals or not sleeping	0	1	4	8
8. Eating starchy foods, even if they are healthy and unprocessed (like rice, corn, beans, whole wheat or oats) causes you to gain weight or prevents you from losing weight	No= 0		Yes= 8	
9. Sores heal slowly	No= 0		Yes= 8	
10. Loss of hair on your legs	No= 0		Yes= 8	
Total points				

PART V

SECTION A

1. Feel jittery	0	1	4	8
2. First physical effort of the day causes pain, pressure, tightness or heaviness around the chest	0	1	4	8
3. Exhaustion with minor exertion	0	1	4	8
4. Heavy sweating (no exertion, no hot flashes)	0	1	4	8
5. Difficulty catching breath, especially during exercise	0	1	4	8
6. Heart pounding, sensation of heart beating too quickly, too slowly, or irregularly	0	1	4	8
7. Swelling in the feet, ankles, and/or legs comes and goes for no apparent reason	0	1	4	8
Total points				

PART V
cont'd

	No/Rarely	Occasionally	Often	Frequently
SECTION B				
1. Muscle pain at rest	0	1	4	8
2. Cramp-like pains in your ankles, calves, or legs	0	1	4	8
3. Numbness, tingling, and prickling sensation in hands and feet	0	1	4	8
4. Cold feet and/or toes appear blue	0	1	4	8
5. Brief moments of hearing loss	0	1	4	8
6. Nausea comes and goes quickly (unrelated to eating)	0	1	4	8
7. Feel worse standing: legs get heavy and fatigued	0	1	4	8
8. Leg discomfort or fatigue relieved by elevating legs	0	1	4	8
9. Fingers and toes get numb in cold weather even when protected	0	1	4	8
10. Notice changes in your ability to feel pain or differentiate between sensations of hot or cold	No= 0		Yes= 8	
11. Body hair (on arms, hands, fingers, legs, and toes) is thinning or has disappeared	No= 0		Yes= 8	
12. Do you notice a decline in your ability to make decisions, concentrate, focus attention, or follow directions?	No= 0		Yes= 8	

Total points ____

PART VI

	No/Rarely	Occasionally	Often	Frequently
SECTION A				
1. Family, friends, work, hobbies, or activities you hold dear are no longer of interest	0	1	4	8
2. Do you cry?	0	1	4	8
3. Does life look entirely hopeless?	0	1	4	8
4. Would you describe yourself as feeling miserable and sad, unhappy, or blue?	0	1	4	8
5. Do you find it hard to make the best of difficult situations?	0	1	4	8
6. Sleep problems—too much or too little sleep	0	1	4	8
7. Changes in your appetite and weight	No= 0		Yes= 8	
8. Lately you've noticed an inability to think clearly or concentrate	No= 0		Yes= 8	
9. Difficulty making decision and/or clarifying and achieving your goals	No= 0		Yes= 8	

Total points ____

SECTION B				
1. Does worrying get you down?	0	1	4	8
2. Does every little thing get on your nerves and wear you out?	0	1	4	8
3. Would you consider yourself a nervous person?	0	1	4	8
4. Do you feel easily agitated?	0	1	4	8
5. Do you shake and tremble?	0	1	4	8
6. Are you keyed up and jittery?	0	1	4	8
7. Do you tremble and feel weak when someone shouts at you?	0	1	4	8
8. Do you become scared at sudden movements or noises at night?	0	1	4	8
9. Do you find yourself sighing a lot?	0	1	4	8
10. Are you awakened out of your sleep by frightening dreams?	0	1	4	8
11. Do frightening thoughts keep coming back in your mind?	0	1	4	8
SECTION B *(cont'd)*				
12. Do you become suddenly scared for no reason?	0	1	4	8
13. Do you break out in a cold sweat?	0	1	4	8
14. "Butterflies in your stomach," nausea and/or diarrhea	0	1	4	8

Total points ____

SECTION C				
1. Do you feel pent up and ready to explode?	0	1	4	8
2. Are you prone to noisy and emotional outbursts?	0	1	4	8
3. Do you do things on impulse?	0	1	4	8
4. Are you easily upset or irritated?	0	1	4	8
5. Do you go to pieces if you don't control yourself?	0	1	4	8
6. Do little annoyances get on your nerves and make you angry?	0	1	4	8
7. Does it make you angry to have anyone tell you what to do?	0	1	4	8
8. Do you flare up in anger if you can't have what you want right away?	0	1	4	8

Total points ____

PART VII

1. Eyes water or tear	0	1	4	8
2. Mucus discharge from the eyes	0	1	4	8
3. Ears ache, itch, feel congested or sore	0	1	4	8
4. Discharge from ears	0	1	4	8
5. Is your nose continually congested?	0	1	4	8
6. Are you prone to loud snoring?	No= 0		Yes= 8	
7. Does your nose run?	0	1	4	8
8. Nosebleeds	No= 0		Yes= 8	
9. Hoarse voice	0	1	4	8
10. Do you have to clear our throat?	0	1	4	8
11. Do you feel a choking lump in your throat?	0	1	4	8
12. Do you suffer from severe colds?	No= 0		Yes= 8	
13. Do frequent colds keep you miserable all winter?	No= 0		Yes= 8	
14. Flu symptoms last longer than 5 days?	No= 0		Yes= 8	
15. Do infections settle in your lungs?	No= 0		Yes= 8	
16. Chest discomfort or pain	0	1	4	8
17. Do you experience sudden breathing difficulties?	0	1	4	8
18. Do you struggle with shortness of breath?	0	1	4	8
19. Difficulty exhaling (breathing out)	0	1	4	8
20. Breathlessness followed by coughing during exertion, no matter how slight	0	1	4	8
21. Inability to breathe comfortably while lying down	0	1	4	8
22. Do you cough up lots of phlegm?	0	1	4	8
23. Can you hear noisy tattling sounds when breathing in and out?	0	1	4	8
24. Are you troubled with coughing?	0	1	4	8
25. Do you wheeze?	0	1	4	8
26. Do you have severe soaking sweats at night?	0	1	4	8
27. Do your lips and/or nails have a bluish hue?	0	1	4	8
28. Are you sleepy during the day?	0	1	4	8

PART VII
cont'd

	No/Rarely	Occasionally	Often	Frequently
29. Do you have difficulty concentrating?	0	1	4	8
30. Eyes, ears, nose, throat, and lung symptoms seem associated with specific foods like dairy or wheat products	No= 0		Yes= 8	
31. Eyes, ears, nose, throat, and lung symptoms are associated with seasonal changes	No= 0		Yes= 8	

Total points ____

PART VIII

1. Involuntary loss of urine when you cough, lift something, or strain during an activity	0	1	4	8
2. Mild lower back ache or pain	0	1	4	8
3. Abdominal achiness or pain	0	1	4	8
4. Pain or burning when urinating	0	1	4	8
5. Rarely feel the urge to urinate	0	1	4	8
6. Feel the need to urinate less than every two hours during the day or night	0	1	4	8
7. Strong smelling urine	0	1	4	8
8. Back or leg pains are associated with dripping after urination	0	1	4	8
9. Sore or painful genitals	0	1	4	8
10. Urine is rose color	0	1	4	8
11. Sudden urge to void causes involuntary loss of urine	0	1	4	8
12. Generalized sense of water retention throughout your body	0	1	4	8

Total points ____

PART IX

SECTION A

1. Bones throughout your entire body ache, feel tender, or sore	0	1	4	8
2. Localized bone pain	0	1	4	8
3. Hands, feet, or throat get tight, spasm, or feel numb	0	1	4	8
4. Difficulty sitting up straight	0	1	4	8
5. Upper back pain	0	1	4	8
6. Lower back pain	0	1	4	8
7. Pain when sitting down or walking	0	1	4	8
8. Find yourself limping or favoring one leg	0	1	4	8
9. Shins hurt during or after exercise	0	1	4	8

Total points ____

SECTION B

1. Are you stiff in the morning when you wake up?	0	1	4	8
2. Difficulty bending down and picking up clothing or anything from the floor	0	1	4	8
3. Joint swelling, pain, or stiffness involving one or more areas (fingers, hands, wrists, elbows, shoulder, toes, arches, feet, hips, knees, or ankles)	0	1	4	8
4. Joints hurt when moving or when carrying weight	0	1	4	8
5. A routine exercise program, like daily walking, causes your knees to swell or hurt	0	1	4	8
6. Difficulty opening jars that were previously easy to open	0	1	4	8
7. Discomfort, numbness, prickling, or tingling sensation, or pain in neck, shoulder, or arm	0	1	4	8

	No/Rarely	Occasionally	Often	Frequently
SECTION B *(cont'd)*				
8. Intermittent pain or ache on one side of head spreading to cheek, temple, lower jaw, ear, neck, and shoulder	0	1	4	8
9. Difficulty chewing food or opening mouth	0	1	4	8
10. Difficulty standing up from a sitting position	0	1	4	8
11. Shooting, aching, tingling pain down the back of leg	0	1	4	8
12. Is it difficult to reach up and get a 5-pound object (like a bag of flour) from just above your head?	No= 0		Yes= 8	
13. Injure, strain, or sprain easily	No= 0		Yes= 8	

Total points ____

SECTION C

1. Muscles stiff, sore, tense, and/or achy	0	1	4	8
2. Burning, throbbing, shooting, or stabbing muscle pain	0	1	4	8
3. Muscle cramps or spasm (involuntary or after exertion/exercise)	0	1	4	8
4. Is muscle pain or stiffness greater in the morning than other times of the day?	0	1	4	8
5. Specific points on the body feel sore when pressed	0	1	4	8
6. Feel unrefreshed upon awakening	0	1	4	8
7. Headaches	0	1	4	8
8. Pain at the sides of your head or in your face especially when awakening	0	1	4	8
9. Your jaw click or pops	0	1	4	8
10. Muscle twitch or tremor—eyelids, thumb, calf muscle	0	1	4	8
11. Irresistible urge to move legs	0	1	4	8
12. Legs move during sleep	0	1	4	8
13. Unpleasant crawling sensation inside calves when lying down	0	1	4	8
14. Hand and wrist numbness or pain (e.g. interferes with writing or with buttoning or unbuttoning your clothes)	0	1	4	8
15. Feeling of "pins and needles" in your thumb and first three fingers	0	1	4	8
16. Pain in forearm and sometimes in shoulder	0	1	4	8

Total points ____

PART X

SECTION A

1. Head feels heavy	0	1	4	8
2. Dizziness	0	1	4	8
3. Difficulty bending over, standing up from sitting, rolling over in bed and/or turning your head from side to side	0	1	4	8
4. Your hands tremble, ever so slightly, for no apparent reason	0	1	4	8
5. You feel like you're wearing heavy weights on your feet when walking	0	1	4	8
6. Bump into things, trip, stumble, and feel clumsy	0	1	4	8
7. Difficulty breathing	0	1	4	8
8. Difficulty swallowing	0	1	4	8
9. People tell you to speak up because they have trouble hearing you	0	1	4	8
10. Speaking and forming words does not feel automatic	0	1	4	8
11. Need 10-12 hours of sleep to feel rested	0	1	4	8

PART X
cont'd

	No/Rarely	Occasionally	Often	Frequently
SECTION A *(cont'd)*				
12. Lack strength (your grip is weak, holding your head, or picking your arms up takes effort)	0	1	4	8
13. Hands get tired when you write and your handwriting is less legible and smaller than it used to be	No= 0		Yes= 8	
14. Muscles in arms and legs seem softer and smaller	No= 0		Yes= 8	
15. Is your eyesight, sense of smell and taste, or ability to hear not as sharp as it used to be?	No= 0		Yes= 8	
16. Do you find yourself moving slower than you used to?	No= 0		Yes= 8	
Total points				
SECTION B				
1. Difficulty absorbing new information	0	1	4	8
2. Tend to forget things	0	1	4	8
3. Trouble thinking or concentrating	0	1	4	8
4. Easily distracted	0	1	4	8
5. Do you have a tendency to become frustrated quickly?	0	1	4	8
6. Inability to sit still for any length of time, even at mealtime	0	1	4	8
7. Finishing tasks is easier said than done	0	1	4	8
8. Do you have more trouble solving problems or managing your time than usual?	0	1	4	8
9. Low tolerance for stress and otherwise ordinary problems	0	1	4	8
Total points				

PART XI

Men Only

1. Sensation of not emptying your bladder completely	0	1	4	8
2. Need to urinate less than 2 hours after you have finished urinating	0	1	4	8
3. Find yourself needing to stop and start again several times while urinating	0	1	4	8
4. Find it difficult to postpone urination	0	1	4	8
5. Have a weak urinary stream	0	1	4	8
6. Need to push or strain to begin urinating	0	1	4	8
7. Dripping after urination	0	1	4	8
8. Urge to urinate several times a night	0	1	4	8
Total points				

PART XII

Women Only

Menopausal women skip to Sections E & F

SECTION A

Do you persistently experience any of these symptoms within 3 days to 2 weeks <u>prior to menstruation</u>?

	No/Rarely	Occasionally	Often	Frequently
[A]				
1. Anxious, irritable or restless	No= 0		Yes= 8	
2. Numbness, tingling in hands and feet	No= 0		Yes= 8	
3. Easy to anger, resentful	No= 0		Yes= 8	
4. Aggressive or hostile toward family / friends	No= 0		Yes= 8	
SECTION A *(cont'd)*				
[B]				
5. Abdominal bloating, feeling swollen (e.g. feet)	No= 0		Yes= 8	
6. Temporary weight gain	No= 0		Yes= 8	
7. Breast tenderness, swelling	No= 0		Yes= 8	
8. Appearance of breast lumps	No= 0		Yes= 8	
9. Discharge from nipples	No= 0		Yes= 8	
10. Nausea and/or vomiting	No= 0		Yes= 8	
11. Diarrhea or constipation	No= 0		Yes= 8	
12. Aches and pains (back, joints, etc.)	No= 0		Yes= 8	
[C]				
13. Craving for sweets	No= 0		Yes= 8	
14. Increased appetite or binge eating	No= 0		Yes= 8	
15. Headaches	No= 0		Yes= 8	
16. Being easily overwhelmed, shaky, or clumsy	No= 0		Yes= 8	
17. Heart pounding	No= 0		Yes= 8	
18. Dizziness or fainting	No= 0		Yes= 8	
[D]				
19. Confused and forgetful to the point that work suffers	No= 0		Yes= 8	
20. Overwhelmed by feelings of sadness and worthlessness	No= 0		Yes= 8	
21. Difficulty sleeping or falling asleep	No= 0		Yes= 8	
22. Engaging in self-destructive behavior	No= 0		Yes= 8	
Total points				
SECTION B				
Do you experience any of these symptoms <u>during your period</u>?				
1. Cramping in lower abdomen or pelvic area	No= 0		Yes= 8	
2. Lower abdominal pain is sharp and/or dull or intermittent	No= 0		Yes= 8	
3. Bloating and sense of abdominal fullness	No= 0		Yes= 8	
4. Diarrhea or constipation	No= 0		Yes= 8	
5. Nausea and/or vomiting	No= 0		Yes= 8	
6. Low back and/or legs ache	No= 0		Yes= 8	
7. Headaches	No= 0		Yes= 8	
8. Unusual fatigue (take naps) resulting in missed work	No= 0		Yes= 8	
9. Painful and/or swollen breasts	No= 0		Yes= 8	
10. Scanty (very light) blood flow	No= 0		Yes= 8	
Total points				
SECTION C				
1. Painful or difficult sexual intercourse	0	1	4	8
2. Low abdominal, back, and vaginal pain throughout the month	0	1	4	8
3. Pelvic pressure or pain while sitting down or standing up, relieved by lying down	0	1	4	8
4. Vaginal bleeding other than during your period	0	1	4	8
5. Painful bowel movements	0	1	4	8
6. Difficult (straining) urination	0	1	4	8
7. Abnormal vaginal discharge	0	1	4	8
8. Offensive vaginal discharge	0	1	4	8
9. Vaginal itching or burning with or without intercourse	0	1	4	8
10. Pain during periods is getting progressively worse	No= 0		Yes= 8	
11. Profuse or prolonged menstrual bleeding	No= 0		Yes= 8	
12. Unable to get pregnant	No= 0		Yes= 8	
Total points				

PART XII
cont'd

SECTION D

	No/Rarely	Occasionally	Often	Frequently
1. Absence of periods for six months or longer	No= 0		Yes= 8	
2. Periods occur irregularly (e.g. 3 to 6 times a year)	No= 0		Yes= 8	
3. Profuse, heavy bleeding during periods	0	1	4	8
4. Menstrual blood contains clots and tissue	0	1	4	8
5. Bleeding between periods can occur anytime	0	1	4	8
6. Periods occur greater than every 35 days	No= 0		Yes= 8	
7. Intense upper stomach pain. Lasting several hours at the time you ovulate (approximately day 14 of your cycle)	0	1	4	8
8. Bleeding occurs at ovulation (approximately day 14 of your cycle)	0	1	4	8
9. Monthly abdominal pain without bleeding	0	1	4	8
10. Abundant cervical mucus	0	1	4	8
11. Acne and/or oily skin	0	1	4	8
12. Overwhelming urges for sexual intercourse	0	1	4	8
13. Aggressive feelings	0	1	4	8
14. Increased growth of dark facial and/or body hair	No= 0		Yes= 8	
15. Poor sense of smell	No= 0		Yes= 8	
16. Voice is becoming deeper	No= 0		Yes= 8	
17. Breasts seem to be getting smaller	No= 0		Yes= 8	
18. Receding hairline	No= 0		Yes= 8	
Total points				

SECTION E

	No/Rarely	Occasionally	Often	Frequently
1. Vaginal discharge	0	1	4	8
2. Vaginal secretions are watery and thin	0	1	4	8
3. Vaginal dryness	0	1	4	8
4. Sexual intercourse is uncomfortable	0	1	4	8

SECTION E *(cont'd)*

	No/Rarely	Occasionally	Often	Frequently
5. Interest in having sex is low	0	1	4	8
6. Engorged breasts				
7. Breast tenderness, soreness	0	1	4	8
8. Difficulty with orgasm	0	1	4	8
9. Vaginal bleeding after sexual intercourse	0	1	4	8
10. Do you skip periods?	No= 0		Yes= 8	
11. The length (number of days) of your period varies month to month, with the number of days of bleeding getting fewer	No= 0		Yes= 8	
Total points				

SECTION F

	No/Rarely	Occasionally	Often	Frequently
1. Sense of well-being fluctuates throughout the day for no apparent reason	0	1	4	8
2. Sudden hot flashes	0	1	4	8
3. Spontaneous sweating	0	1	4	8
4. Chills	0	1	4	8
5. Cold hands and feet	0	1	4	8
6. Heart beats rapidly or feels like it's fluttering	0	1	4	8
7. Numbness, tingling, or prickling sensations	0	1	4	8
8. Dizziness	0	1	4	8
9. Mental fogginess, forgetful, or distracted	0	1	4	8
10. Inability to concentrate	0	1	4	8
11. Depression, anxiety, nervousness, and/or irritability	0	1	4	8
12. Difficulty sleeping	0	1	4	8
13. Conscious of new feelings of anger and frustration	0	1	4	8
14. Skin, hair, vagina, and/or eyes feel dry	0	1	4	8
15. Stopped menstruating around six months ago, yet still experience some vaginal bleeding	No= 0		Yes= 8	
Total points				

What is the primary reason you are seeing the doctor?

You can also use this area to note any questions, concerns, or other things that you would like to discuss with the doctor.

