

Women's Health Questionnaire

Use each of the checklists below to help determine which profile is appropriate for you.

see reverse for Spanish

Profile 1

Do you have or have you experienced the following in the past six months:

- | | | |
|--|--|--|
| <input type="checkbox"/> Autoimmune diseases (Z13.228) | <input type="checkbox"/> Lung disease (R06.02) | <input type="checkbox"/> High blood pressure or medication use (I11.9) |
| <input type="checkbox"/> Susceptibility to infections (Z00.00) | <input type="checkbox"/> Snoring while sleeping (R06.83, G47.33) | <input type="checkbox"/> Abnormal cholesterol or medication use (E78.5) |
| <input type="checkbox"/> Slow wound healing (T81.30) | <input type="checkbox"/> Osteoporosis / brittle bones (M81.0) | <input type="checkbox"/> Heart disease (I70.90) |
| <input type="checkbox"/> Decreased stamina (R53.1) | <input type="checkbox"/> Osteoarthritis (M15.9) | <input type="checkbox"/> History of stroke / TIA (G45.9, I63.9) |
| <input type="checkbox"/> Tobacco use (F17.210) | <input type="checkbox"/> Memory loss (R41.3) | <input type="checkbox"/> Family history of heart disease (Z82.49) |
| <input type="checkbox"/> Daily alcohol consumption (F10.99) | <input type="checkbox"/> Diabetes / pre-diabetes (E11.8, R73.01) | <input type="checkbox"/> Family history of diabetes (Z83.3) |
| <input type="checkbox"/> Prescription medication use (Z79.899) | <input type="checkbox"/> Abnormal blood sugar (R73.09) | <input type="checkbox"/> Large waist circumference (high risk >40") (E88.81) |
| <input type="checkbox"/> Constipation (<1 movement/day) (K59.00) | <input type="checkbox"/> Decreased sweating (E88.9) | <input type="checkbox"/> Recreational drug use (F12.99) |
| <input type="checkbox"/> Gas / bloating (R14.0, R14.3) | <input type="checkbox"/> Recent weight gain (R63.5) | <input type="checkbox"/> Asthma / Wheeze (J45.909, R06.2) |
| <input type="checkbox"/> Indigestion / Heartburn (R12) | <input type="checkbox"/> Pigmented skinfolds (E88.81) | <input type="checkbox"/> Chronic cough (R05) |
| <input type="checkbox"/> Food cravings (R63.2) | <input type="checkbox"/> Skin tags (fleshy protrusions) (E88.81) | <input type="checkbox"/> Excessive thirst (R63.1) |
| <input type="checkbox"/> Irritable bowels (K58.9) | <input type="checkbox"/> Gout (E79.0) | <input type="checkbox"/> Dry mouth (R68.2) |
| <input type="checkbox"/> Kidney disease (N18.9) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Sinus congestion (R09.81) |
| <input type="checkbox"/> Fatty liver disease (K76.9) | <input type="checkbox"/> Varicose veins (I83.90) | |
| <input type="checkbox"/> Gall bladder attacks (K80.21) | <input type="checkbox"/> History of blood clots (I80.299) | |

Profile 2

Do you have or have you experienced the following in the past six months:

- | | | |
|--|--|---|
| <input type="checkbox"/> Infrequent morning erections (R68.82) | <input type="checkbox"/> Prostate problems (N40.0) | <input type="checkbox"/> Excess sweating (R61) |
| <input type="checkbox"/> Sexual thoughts (<2-3 times a month) (F52.9) | <input type="checkbox"/> Decreased urine flow (R39.19) | <input type="checkbox"/> Heart palpitations (R00.2) |
| <input type="checkbox"/> Erectile dysfunction (N52.9) | <input type="checkbox"/> Increased urinary urge (R39.19) | <input type="checkbox"/> Using hormone medication (Z79.3) |
| <input type="checkbox"/> Sadness (R45.2) | <input type="checkbox"/> Decreased muscle mass (R53.1) | <input type="checkbox"/> Increased back hair (L68.0) |
| <input type="checkbox"/> Low energy (R53.82) | <input type="checkbox"/> Feeling burnt out (R53.83) | <input type="checkbox"/> Excess hair loss (L64.9) |
| <input type="checkbox"/> Fatigue (R53.82) | <input type="checkbox"/> Inability to lose weight (E66.3) | <input type="checkbox"/> Excess body odor (R46.0) |
| <input type="checkbox"/> Inability to walk more than 1 km (R53.81) | <input type="checkbox"/> Water retention (R60.9) | <input type="checkbox"/> Swelling of feet / ankles (R60.9) |
| <input type="checkbox"/> Decreased flexibility--can't bend or kneel (M25.60) | <input type="checkbox"/> Sleep disturbance (G47.00) | <input type="checkbox"/> Migraines (G43.0) |
| <input type="checkbox"/> Not able to engage in vigorous activity (R53.1) | <input type="checkbox"/> Fatigue / drowsiness (R53.83, R40.0) | <input type="checkbox"/> Low blood pressure (R03.1) |
| <input type="checkbox"/> Low motivation levels (R45.84) | <input type="checkbox"/> Dark circles / bags under eyes (R53.83) | <input type="checkbox"/> Using antidepressant medications (F32.9, F13.29) |
| <input type="checkbox"/> Decreased mental sharpness (R41.840) | <input type="checkbox"/> Hypothyroid (E03.9) | |
| <input type="checkbox"/> Fertility problems (E29.9) | <input type="checkbox"/> Cold hands and feet (E88.9) | |

Profile 3

Do you have or have you experienced the following in the past six months:

- | | | |
|--|---|--|
| <input type="checkbox"/> Excessive / chronic stress (R45.7) | <input type="checkbox"/> Fibromyalgia (M79.7) | <input type="checkbox"/> Dry / rough skin (R23.4) |
| <input type="checkbox"/> Mood fluctuations (R45.86) | <input type="checkbox"/> Leg pain (M79.609) | <input type="checkbox"/> Thin skin / poor elasticity (R23.9) |
| <input type="checkbox"/> Irritable (R45.1) | <input type="checkbox"/> Back pain (M54.89) | <input type="checkbox"/> Food allergies (T78.40) |
| <input type="checkbox"/> Anger outbursts (R45.4) | <input type="checkbox"/> Joint pain (M25.50) | <input type="checkbox"/> Hives / itchy skin (L50.9) |
| <input type="checkbox"/> Depressed (F32.9) | <input type="checkbox"/> Numbness / tingling (R20.2) | <input type="checkbox"/> Skin breakouts / flares (R21) |
| <input type="checkbox"/> Anxiety (R45.82, F41.1) | <input type="checkbox"/> Using steroid medication (E24.9) | <input type="checkbox"/> Dark skin discolorations around neck (E88.81) |
| <input type="checkbox"/> Foggy thinking / disorientation (R41.840) | <input type="checkbox"/> Purple / pink stretch marks (E24.9) | <input type="checkbox"/> Increased wrinkles (R23.9) |
| <input type="checkbox"/> Need caffeine to get going (R53.83) | <input type="checkbox"/> Excess belly hip fat (E28.0, E66.3, E66.0) | <input type="checkbox"/> Acne / oily skin (L70.9) |
| <input type="checkbox"/> Morning fatigue (G47.9) | <input type="checkbox"/> Headaches (G44.229) | <input type="checkbox"/> Immune or hormone skin cream use (Z79.3) |
| <input type="checkbox"/> Feel run down (R40.0) | <input type="checkbox"/> Using pain / anxiety medication (F11.99) | <input type="checkbox"/> Sugar cravings (E63.1) |
| <input type="checkbox"/> Feel wired before bed (G47.9) | <input type="checkbox"/> Eczema (L30.9) | <input type="checkbox"/> Recent / pending surgery/procedure (Z01.818) |
| <input type="checkbox"/> Avoid / lacking a suntan (E55.9) | <input type="checkbox"/> Psoriasis (L40.9) | |
| <input type="checkbox"/> Chronic pain (G89.29) | <input type="checkbox"/> Thinning hair (L64.9) | |

Talk to your practitioner about preforming advanced blood testing to:

(1) Find the root cause of your symptoms & concerns (2) Uncover hidden risks (3) Know your baseline

Name: _____ Signature: _____ Date: _____

Potential ICD-10 codes provided for your convenience only. Physician should note diagnosis codes that are most appropriate for their patient.