Women's Quality of Life Questionaire

Name _____ Date_____

Have you currently or previously taken any birth control/ hormone pills or shots?
No Yes *If yes, please specify Please include alternative/herbal meds*

Medication	Dose	Date Started/Ended	Reason

If you have used birth control now or in the past, did you have any problems with the method you used- physically or psychologically? _____

_____

Age of First Menstrual period _____

Circle the appropriate number(s) in section A ,B, & C that apply:

A. Current childbearing potential
1=childbearing Current birth control method if applicable_____

2= post-menopausal date of last menses_____

3= surgically sterile date and type of procedure_____

4= other _____

B. Childbearing history:
0= never been pregnant
1= never given birth
2= has given birth _____Pregnancies
_____Abortions
_____Miscarriage

C. Infertility Problems No ☐ Yes ☐
If yes, please describe and how has this affected you. _____

_____

Describe your menstrual cycle. Do you have pain, discomfort or extremely heavy/ light periods? _____

_____

Have you had any mood symptoms associated with menstrual cycle--- before, during, after? Yes No *if yes, please describe*

_____

_____

_____

Have you had any mood symptoms associated with pregnancies—before, during, after?
Yes No *if yes, please describe*

_____

_____

_____

Have you had any mood symptoms associated with peri-menopause (10 years prior to onset of menopause to 1 year after the complete cessation of your periods?
Yes No *if yes, please describe*

_____

_____

Describe your experience with menopause. What symptoms did you have? Did you receive treatment? Any mood symptoms? If so, what?

_____

_____

What has it meant for you to reach menopause?_____

_____

Degree of Stress in your life at present? ☐ *1 being lowest amount of stress 10 being highest amount of stress*

Job _____ Family _____ General Life_____ Other_____

Please elaborate

_____

_____

_____

Do you have any physical symptoms that you think are caused by stress? Yes No
Please elaborate-

_____

_____

Symptom Checklist- Please check off symptoms below that apply or have applied.

☐ anxiety ☐ panic attacks ☐ sadness ___mood swings

___ obsessions ___ compulsions ___hallucinations ___ fears/phobias

___ sleep problems ___ tics/grunts/jerks ☐ irritability/ anger/ short fuse

☐ eating binges ___ restricting food too much ___gambling/ shopping to extreme

☐ PMS ☐ post partum depression ___ low self esteem

☐ body image problems ___ chronic aches/pain

Elaborate if needed

_____

_____

_____

_____

General Health:

How is your general health? Any major health problems?

_____

_____

Health of spouse/ significant other _____

Health of children _____

Health of other family members/close friends_____

Have any of the health issues pertaining to you or your close ones affected you psychologically? ☐ Yes ☐ No *if yes, please describe*

_____

_____

Have you experienced any significant losses, separations, transitions or changes in your life that you haven't quite gotten over?

_____

_____

Describe any significant memories from childhood that you feel might be affecting you.

_____

_____

Did you ever witness or experience a violent or traumatic life event? Have you ever been a victim of sexual abuse or rape?

_____

_____

How is aging affecting you? _____

_____

Have you had any problems with sexual desire/ activity? Yes ☐ No ☐
If yes, please explain

_____

_____

_____

Have you suffered psychologically or physically because of problems associated with sexual desire/ activity? Yes ☐ No ☐
If yes, please explain

_____

_____

If you have any other comments or explanations, please elaborate below

_____

_____

_____

_____

_____

_____

_____