Women's Health Appraisal Questionnaire

DIGESTIVE SYSTEM (PLEASE TICK ONLY ONE BOX PER LINE)	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Indigestion			
Excessive belching, burping			
Bloating (feeling off heaviness, fullness in stomach region)			
Bad breath			
History of anaemia/low iron			
Indigestion with particular foods			
Heartburn			
Constipation			
Vomiting			
Excessive wind/gas			
Diarrhea			
Alternating constipation/diarrhea			
Undigested food in stool			
Mucus in stool			
Blood in stool			
Haemorrhoids/anal fissures			
Anal itching			
Fatigue			
Suffer from gum disease / gingivitis			
Amalgam fillings			
Dental implants			

CARDIOVASCULAR SYSTEM	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Excessive fatigue (feeling tired most of the time)			
Feeling worse after exercise			
Dizzy spills			
Yellow of eyes or skin			
Red sore tongue			
Diagnosis with hypertension			
Swelling of feet/ankles			
Need coffee, tea, choc as pick me ups			
Intolerance to cold			
Swelling/tightness in front of neck			
Weight gain			
Poor memory			
Feeling hot, sweaty			
Insomnia			
Irritable/over-sensitive			
Low mood, mood swings			
Memory problems			
Fluid retention			

Women's Health Appraisal Questionnaire

Julide Türker

REPRODUCTIVE SYSTEM – SYMPTOMS EXPERIENCED IN LAST 3 MONTHS	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Excessive libido			
Use of Contraceptive pill			
Dry skin, hair or vagina			
Painful intercourse			
Vaginal dryness or pain			
Thinning of armpit and pubic hair, or increased upper lip hair growth			
Hot flushes			
Breast tenderness, swelling or lumps			
Breasts shrinking, reducing in size or starting to sag			
Painful periods – lower abdomen or back			
Pain with periods is worsening			
Painful intercourse during menstruation			
Pelvic and/or rectal pressure around menstruation			
Prolonged duration of Bleeding			
Constipation or diarrhoea with menstruation			
Prolonged duration of Bleeding			
Absence of period for more than five months			
Vaginal bleeding after intercourse or between periods			
Thinning body hair			
Milk production (not nursing),or engorged breasts			
Burning or itching of external genitalia			
Vaginal bleeding after intercourse or between periods			
Lower abdominal or back pain			
Breast lumps, or a change in breast size or shape			
Nipple discharge, or change in appearance of nipple			
Swelling under armpit			
Nausea and/or vomiting with menstruation			
Light blood flow			
Heavy blood flow or flooding			
Passage of large or profuse blood clots			
Cycles longer than 32 days			
Cycles shorter than 24 days			
Irregular menstrual cycle or changes with menstrual flow			
Vaginal bleeding between periods			
Facial hair			
Abdominal weight gain			
Painful periods			
Clotting with periods			
Absence of period for more than 3 months			

Women's Health Appraisal Questionnaire

REPRODUCTIVE SYSTEM – CONTINUED	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Peri-menopausal			
Menopausal - hot flushes or night sweats			
Miscarriage			
Infertility			
Excessive vaginal discharge, smelly or colored			
Absent or light periods			
Poor or low libido (lack of desire for sexual intercourse more often than not)			

IMMUNE SYSTEM	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Nasal congestion			
Hay fever			
Cough with mucus			
Dry cough			
Cold sores			
Swelling in groin/neck/armpit			
Wounds heal slowly			
Excessive loss of hair, thinning of body or facial hair or slow hair growth			
Headaches			
Sensitive to light			
Dark circles under eyes			
Itching all over the body			
Rash/eczema			
Incontinence			
Burning sensation upon urination			
Thrush (on the genital region, white plaques or itching)			
Athlete's foot (fungal infection between toes)			

MOOD AND SKIN	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Acne			
Oily skin			
Dry skin			
Feeling depressed, teary or sensitive			
Feeling aggressive, anxious, on edge , irritable or easily angered			
Feeling suicidal, having thoughts of self harm or suicide			
Feeling the urge to harm others			
Mood swings, irritability, depression, nervousness, anxiety			
Clumsiness			
Headaches or dizziness			
Difficulty concentrating, poor memory or confusion			
Memory, or confusion			
Headaches or migraines			

Women's Health Appraisal Questionnaire

TOXIC EXPOSURE IN THE HOME	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Mould growth			
Breast implants			
Water filter used			
Skincare brand(s)			
Use of aluminium in the kitchen re pots / pans and or foil			
Home cleaning product brand(s) *(answer here)*			
Where is the wifi portal located? *(answer here)*			
Do you consume organic produce, if so specify please *(answer here)*			

GENERAL HEALTH HISTORY

Please list any medications you have taken in the last 6 months & what you are currently taking.

DRUG NAME	DOSAGE	THE DATE IN WHICH YOU STARTED YOUR TREATMENT

List of any other over-the-counter herbal, vitamin or homeopathic supplements you are taking.

ALL (OVER THE COUNTER) SUPPLEMENTS / HOMEOPATHICS	DOSAGE	THE DATE IN WHICH YOU STARTED YOUR TREATMENT

Women's Health Appraisal Questionnaire

GENERAL HEALTH HISTORY

Please list any surgeries you have had in the past, please insert the year of the surgery:

Please list your current health concerns that we will be addressing:

List any family history of diseases on both sides of the family:

List any other relative comments:

Thank you for taking out the time to acknowledge the challenges that you are currently experiencing and be ready to actively make changes that will enhance your physical, mental and emotional wellness. Get ready to be blown away by the power of change that you have allowed yourself to experience. You are worth it.

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