Optimal Aging Women's Questionnaire

Name ____

Age ________

Weight ______

Smoker YES / NO

Birth Control _________________________

Still Menstruating YES / NO

Hot Flashes YES / NO

Currently on hormonal treatment YES / NO

If yes, name and dose __________________________

Currently on thyroid medication YES / NO

If yes, name and dose __________________________

Do you have/are you:

Pregnant	YES / NO
Hashimoto's Thyroiditis	YES / NO
History of Breast Cancer	YES / NO
Hysterectomy	YES / NO
Fibrocystic Breast Disease	YES / NO
PCOS (Polycystic Ovary Syndrome)	YES / NO
History of Leiomyoma or Endometrial Polyps	YES / NO