

BitterRoot Natural Medicine
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PCOS Consult

naturopathic physician/counseling for change

PCOS Consultation Health/Intake Form

Name: _____

Email: _____

Phone: _____

Birthdate: _____

Personal History

Have you been formally diagnosed by a physician as having PCOS? yes no

Do you have: (please circle or write in response)

- Irregular menses? yes no
- cycles less than 24 days/more than 35 days
- What is the longest time you have gone without a period?
- Did you ever have regular periods without taking birth control pills?
- How many pregnancies? _____ How many children? _____ Miscarriages? _____
- Have you tried to get pregnant without success for more than one year? yes no
- Have you ever been on any kind of hormone therapy to regulate your periods? (birth control pills, implants, shots ; please list what you have used. Use the back of the page if needed)

• How much did you weigh when you were born? _____

• As a child, did you have any of the following:

pubic hair growing before age 8? yes no excess weight or obesity? yes no

tend to be sleepy after a meal? yes no

darkening of the skin on the back of your neck? yes no

• Do any family members (parents, siblings, grandparents, aunts, uncles, cousins) have: (circle)

excess female facial hair obesity

high cholesterol

irregular menses

diabetes

thin scalp hair before age 30

PCOS Consult

- Looking back and knowing what you know now, what were the first signs that you might have PCOS, and at what age did you first notice these? Leave blank if any of these symptoms have not been a part of your experience.

obesity? age: _____

acne? age: _____

facial hair? age: _____

abdominal hair? age: _____

thin scalp hair? age: _____

irregular periods? age: _____

Which of these signs are the most bothersome to you? _____

Which is the least bothersome to you? _____

Health Care History

Have you been diagnosed with PCOS? yes no

blood pressure? _____

Please provide copies of recent diagnostic tests.

The following are the most beneficial to get started. Please provide copies of your recent results.

- fasting glucose
- fasting insulin
- fasting cholesterol
- thyroid function TSH T4 T3Uptake
- pelvic ultrasound

Height: _____ inches

Weight: _____ pounds

Waist: _____ inches

Hips: _____ inches

Please describe your diet. If it has become significantly since your diagnosis, please also describe what it was like before you made changes. Use a separate sheet of paper and tell me how much (ounces, cups, pieces) and how often (3 times a day, once a month) you eat or drink:

Beverages

water
alcohol
cow milk
fruit juice (what kind? _____)
yogurt (plain, vanilla, fruit), buttermilk, sour cream, quark, etc

tea (black/green/herbal)
novelty beverages (Snapple/Sobee/Nestea, etc)
half & half/ creamer
soy milk

coffee
soda/pop
rice milk

Proteins

beef
finned fish

game (venison, elk)
shell fish

turkey
eggs

chicken
soy foods

Carbohydrates

bread (wheat/spelt/rye/etc)
pasta, noodles
whole grains (brown rice, white rice, millet, quinoa, barley)
cereals (granola, cheerios, corn puffs, flakes, oatmeal)
cookies, cakes, pies, other desserts, candy, sugar, syrups, honey
vegetables (starchy-like potatoes, squash, light like salads, cooked like broccoli)
fruits (fresh, dried, canned, frozen)
legumes (lentils, peanuts, beans, peas)

bagels, crackers, pita, tortilla, chapatti
chips (potato, corn)

Fats

oils—what kind? (olive, canola, vegetable, sesame, sunflower)
nuts (almonds, walnuts, pecans, brazil)
dairy cheese (cheddar, mozzarella, parmesan, cottage, etc)
butter
Packaged foods, frozen dinners, fast food, deli/ take-out, restaurant meals

ghee
margarine, Crisco, Pam

seeds (sunflower, sesame, pumpkin)

