



HIRSUTISM/AMENORRHEA EVALUATION

NAME: _____ MR# _____ DATE: _____

I. **AMENORRHEA** (LOSS/LACK OF PERIODS)

START DATE OF
 AGE OF 1ST PERIOD _____ LAST MENSTRUAL PERIOD _____
 LAST PAP & PELVIC EXAM _____ (MONTH & YEAR)
 # OF PREVIOUS PREGNANCIES _____ # OF CHILDREN _____
 DESCRIBE YOUR USUAL PERIOD: CYCLES: REGULAR IRREGULAR (CIRCLE ONE)
 LENGTH: _____ (# OF DAYS) TIME IN BETWEEN CYCLES: _____ (# OF DAYS)
 FLOW: (LIGHT, MEDIUM, HEAVY)
 ANY CHANGE OVER PAST SIX MONTHS? _____ IF SO WHAT? _____

PLEASE CIRCLE CORRECT RESPONSE

ANY DIFFICULTIES BECOMING PREGNANT? Y / N
 ANY PREVIOUS INFERTILITY EVALUATION? Y / N IF YES, WHEN? _____
 WHERE? (MD OR CLINIC) _____ TREATMENT? _____
 ANY PREVIOUS ENDOMETRIAL BIOPSY OR CANCER? Y / N IF YES WHEN? _____
 WHERE? (MD OR CLINIC) _____ RESULT? _____
 ANY DIFFICULTIES WITH PREGNANCY? Y / N DELIVERY? Y / N INFANT'S HEALTH? Y / N
 DESCRIBE _____

II. **HIRSUTISM** (EXCESS/ABNORMAL HAIR GROWTH)

PLEASE CIRCLE CORRECT RESPONSE

A. ETHNIC BACKGROUND: CAUCASIAN NORDIC ORIENTAL
 MEDITERRANEAN HISPANIC AFRO-AMERICAN OTHER: _____

B. WHAT AGE DID ABNORMAL HAIR GROWTH BEGIN? _____

C. WHERE AND IN WHAT ORDER?
 CHIN # _____ UPPER LIP # _____ SIDEBURNS # _____
 FULL BEARD # _____ UPPER CHEST # _____ BREASTS # _____
 LOWER STOMACH # _____ INNER THIGHS # _____ LOWER BACK # _____
 ARMS # _____ LEGS # _____ CHEEKS # _____

D. IS IT . . . ? GETTING WORSE STAYING THE SAME IMPROVING (CIRCLE ONE)

E. HAVE YOU . . . ? SHAVED _____ PLUCKED _____ BLEACHED _____
 USED HAIR REMOVAL PRODUCT _____ HAD ELECTROLYSIS _____ WAXED _____
 DESCRIBE _____

F. HAVE YOU EVER TAKEN ANY OF THESE MEDICATIONS? (CIRCLE ALL THAT APPLY)
 MINOXIDIL STEROIDS TESTOSTERONE PREDNISONE DANAZOL
 DILANTIN (PHENYTOIN) DIAZOXIDE (PROGLYCEM)

G. ANY PREVIOUS TREATMENT FOR HAIR GROWTH? Y / N (EXAMPLES: ALDACTONE,
 SPIRONOLACTONE, DECADRON, DEXAMETHASONE, BIRTH CONTROL PILLS)
 IF SO WHEN? _____ WHERE (MD OR CLINIC) _____
 DESCRIBE _____

H. ANY FAMILY HISTORY OF
 HIRSUTISM _____ POLYCYSTIC OVARIAN DISEASE _____
 INFERTILITY _____ DIABETES _____
 OBESITY _____ BREAST CANCER _____
 ENDOMETRIAL CANCER _____ OTHER _____

DO YOU HAVE THE FOLLOWING SYMPTOMS? (CHECK ALL THAT APPLY)

<input type="checkbox"/> HISTORY OF HIGH BLOOD PRESSURE	<input type="checkbox"/> HISTORY OF OSTEOPOROSIS
<input type="checkbox"/> HIGH BLOOD SUGAR	<input type="checkbox"/> HISTORY OF LIVER PROBLEMS
<input type="checkbox"/> HISTORY OF THYROID PROBLEMS	<input type="checkbox"/> OVERWEIGHT? _____ HOW LONG? _____
<input type="checkbox"/> OILY SKIN	<input type="checkbox"/> ACNE/PIMPLES
<input type="checkbox"/> BALDING / SCALP, HAIR LOSS	<input type="checkbox"/> STRETCH MARKS
<input type="checkbox"/> DARKENING OF THE SKIN (WHERE)	<input type="checkbox"/> EASY BRUISING
<input type="checkbox"/> FREQUENT URINATION OR THIRST	<input type="checkbox"/> BREAST SECRETIONS
<input type="checkbox"/> CHANGE IN BREAST SIZE (↑ / ↓)	<input type="checkbox"/> CHANGE IN MUSCULARITY
<input type="checkbox"/> CHANGE IN SEX DRIVE (↑ / ↓)	<input type="checkbox"/> VOICE CHANGE
<input type="checkbox"/> INCREASED SWEATING	<input type="checkbox"/> CHANGE IN ADAMS APPLE
<input type="checkbox"/> INCREASED SPACE BETWEEN TEETH	<input type="checkbox"/> CHANGE IN RING OR SHOE SIZE