BMG | THE ENDOCRINE CLINIC

HIRSUTISM / AMENORRHEA EVALUATION

Name: _____ MR #: _____ Today's Date: _____

I. **AMENORRHEA** (Loss/Lack of Periods)

Age of 1st Period: _____ Start Date of Last Menstrual Period: _____
Last Pap & Pelvic Exam: _____ (Month & Year)
# of Previous Pregnancies: _____ # of Children: _____
Describe Your Usual Period: Cycles: ☐ Regular ☐ Irregular
Length: _____ (# of Days) Time in Between Cycles: _____ (# of Days)
Flow: ☐ Light ☐ Medium ☐ Heavy
Any Change Over Past Six Months? _____ If so, what? _____

Please Check Correct Response

Any Difficulties Becoming Pregnant? ☐ Yes ☐ No
Any Previous Infertility Evaluation? ☐ Yes ☐ No If Yes, when? _____
Where? (MD or Clinic) _____ Treatment? _____
Any Previous Endometrial Biopsy or Cancer ☐ Yes ☐ No If Yes, when? _____
Where? (MD or Clinic) _____ Result? _____
Any Difficulties With Pregnancy? ☐ Yes ☐ No Delivery? ☐ Yes ☐ No Infant's Health? ☐ Yes ☐ No
Describe: _____

II. **HIRSUTISM** (Excessive/Abnormal Hair Growth)

Please Check 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 # _____	Arms # _____	Inner Thighs # _____	Breasts # _____
Full Beard # _____	Upper Lip # _____	Legs # _____	Lower Back # _____
Lower Stomach # _____	Upper Chest # _____	Sideburns # _____	Cheeks # _____

D. Is It…? ☐ Getting Worse ☐ Staying the Same ☐ Improving
E. Have You…? ☐ Shaved ☐ Plucked ☐ Bleached ☐ Used Hair Removal Product ☐ Had Electrolysis ☐ Waxed
Describe: _____
F. Have You Ever Taken Any of These Medications? (Check all that apply) ☐ Minoxidil ☐ Steroids ☐ Testosterone
☐ Prednisone ☐ Danazol ☐ Dilantin (Phenytoin) ☐ Diazoxide (Proglycem)
G. Any Previous Treatment for Hair Growth? ☐ Yes ☐ No (Examples: Aldoactone, Spironolocatone, 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 Follow Symptoms? (Check All That Apply)

☐ History of High Blood Pressure	☐ Change in Sex Drive (↑ / ↓)	☐ Easy Bruising
☐ High Blood Sugar	☐ Increased Sweating	☐ Breast Secretions
☐ History of Thyroid Problems	☐ Increased Space Between Teeth	☐ Change in Muscularity
☐ Oily Skin	☐ History of Osteoporosis	☐ Voice Change
☐ Balding / Scalp, Hair Loss	☐ History of Liver problems	☐ Change in Adams Apple
☐ Darkening of the Skin (Where)	☐ Overweight. How Long? _____	☐ Change in Ring or Shoe Size
☐ Frequent Urination or Thirst	☐ Acne/Pimples	
☐ Change in Breast Size (↑ / ↓)	☐ Stretch Marks	