POLYCYSTIC OVARY SYNDROME (PCOS) - EVALUATION

Last name:_____ First name:_____ Middle initial _____

Age: _____

PCOS MANAGEMENT GOALS

What are your top 2-3 goals for PCOS Management?

1. _____
2. _____
3. _____

Describe any barriers you have to achieve these goals:

_____
_____
_____
_____

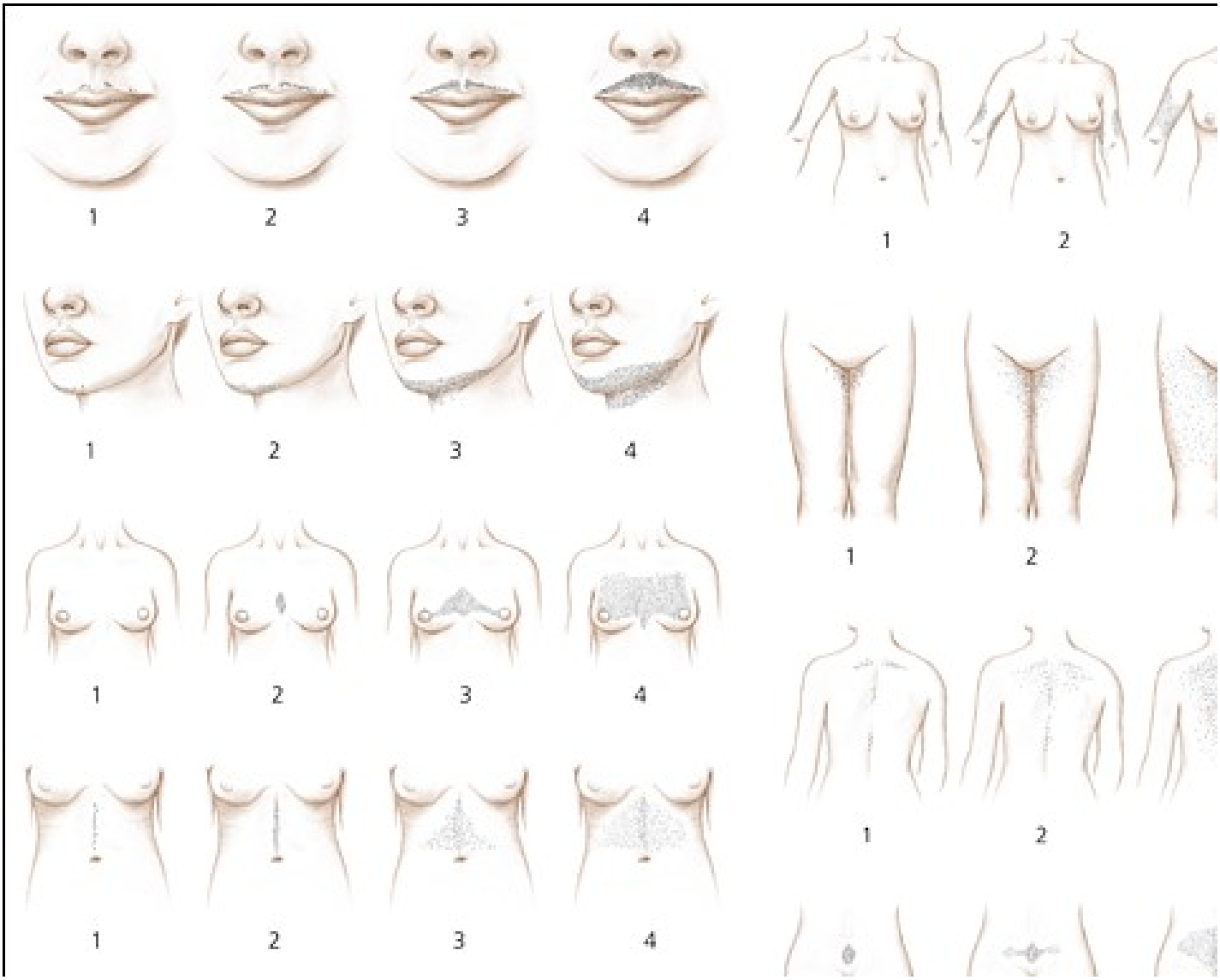
PRIOR TREATMENTS

Please describe any ways or treatments you have done thus far to manage your PCOS:

_____
_____
_____
_____
_____

HAIR GROWTH PATTERN

Please circle your hair growth pattern below:



Do you want to remove hair growth? If yes, what things have you tried?

_____
_____
_____
_____

NUTRITION

Help me understand your nutrition by describing your typical 3-day food diary:

Food Diary	Day 1	Day 2	Day 3
Morning			
Lunch			
Dinner			
Snacks			
Drinks			

Would you like things to be different with your diet? If yes, how so?

_____
_____
_____
_____

What/if anything have you tried before to make a change to your diet? How did it go?

_____
_____
_____
_____

PHYSICAL ACTIVITY

What do you like to do for physical activity, movement, or for fun?

Help me understand your current physical activity habits by describing a typical week for you:

Would you like things to be different with your physical activity? If yes, how so?

What/if anything have you tried before to make a change? How did it go?

SLEEP PATTERNS

Tell me about your current sleep habits:

What are the good things about your sleep habits and what are the less good things?

PCOS Screening Health Questionnaire

As part of SRM's PCOS Wellness Program, we ask that you complete the following questionnaire. Please read and answer the following questions truthfully and to the best of your knowledge. We recognize that some of the questions are of a sensitive nature and thank you for providing the most accurate information.

1. Anxiety Screening

Over the last 2 weeks, how often have you been bothered by the following symptoms?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritated	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐
8. If you check off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

2. Depression Screening

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐

8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
10. If you check off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

3. Sleep Disorder Screening

Do you snore, wake unrefreshed from sleep, or have daytime sleepiness? If yes, please complete the following questions. If no, okay to skip this section					
1. Is your snoring?	☐ Slightly louder than breathing	☐ As loud as talking	☐ Louder than talking	☐ Very loud, can be heard from adjacent room	
2. Has your snoring ever bothered other people?	☐ Yes	☐ No	☐ Do not know		
3. Do you have high blood pressure?	☐ Yes	☐ No	☐ Do not know		
4. How often do you snore?	☐ Nearly every day	☐ 3-4 times a week	☐ 1-2 times a week	☐ 1-2 times a month	☐ Never or nearly never
5. Has anyone noticed that you quit breathing during your sleep?	☐ Nearly every day	☐ 3-4 times a week	☐ 1-2 times a week	☐ 1-2 times a month	☐ Never or nearly never
6. How often do you feel tired or fatigued after your sleep?	☐ Nearly every day	☐ 3-4 times a week	☐ 1-2 times a week	☐ 1-2 times a month	☐ Never or nearly never
7. During your wake time, do you feel tired, fatigued or not up to par?	☐ Nearly every day	☐ 3-4 times a week	☐ 1-2 times a week	☐ 1-2 times a month	☐ Never or nearly never
8. Have you ever nodded off or fallen asleep while driving a vehicle? If yes, how often does this occur?	☐ Nearly every day	☐ 3-4 times a week	☐ 1-2 times a week	☐ 1-2 times a month	☐ Never or nearly never

4. Disordered Eating Screening

SCOFF Questionnaire		
S – Do you make yourself Sick because you feel uncomfortably full?	☐ Yes	☐ No
C – Do you worry you have lost Control over how much you eat?	☐ Yes	☐ No
O – Have you recently lost more than 14 pounds in a three-month period?	☐ Yes	☐ No

F – Do you believe yourself to be Fat when others say you are too thin?	☐ Yes	☐ No
F – Would you say Food dominates your life?	☐ Yes	☐ No