

HIRSUTISM PATIENT QUESTIONNAIRE

1. When did your excess hair growth begin? _____

2. Has it increased rapidly or slowly? (*circle one*) RAPIDLY SLOWLY
3. Have you noticed increased hair growth in the following locations?

| | | |
|-----------------------|-----------|------------|
| face | <i>no</i> | <i>yes</i> |
| near nipples | <i>no</i> | <i>yes</i> |
| lower abdomen | <i>no</i> | <i>yes</i> |
| arms | <i>no</i> | <i>yes</i> |
| legs | <i>no</i> | <i>yes</i> |
| upper back | <i>no</i> | <i>yes</i> |
| shoulders | <i>no</i> | <i>yes</i> |
| middle of chest | <i>no</i> | <i>yes</i> |
| upper abdomen | <i>no</i> | <i>yes</i> |

4. Is the hair on your scalp significantly thinner than it used to be? (*circle one*) YES NO
5. How many days between menstrual periods? _____
6. Is this a regular cycle for you? (*circle one*) YES NO
7. If no, when did irregularity begin? _____
8. How many days does your menstrual flow last? _____
9. If you have irregular periods or long menstrual flows, has this been evaluated by a gynecologist or other physicians? _____
10. Have you notice enlargement of your clitoris? (*circle one*) YES NO
11. Current weight _____
12. Most you ever weighed: _____ when? _____
Least you ever weighed: _____ when? _____
13. Do you have high blood pressure? (*circle one*) YES NO
14. If yes, when was your high blood pressure first noted? _____
15. Do you feel extremely fatigued most of the time? (*circle one*) YES NO _____
16. Do you feel colder than other people most of the time (*circle one*) YES NO
17. Do you have diabetes? (*circle one*) YES NO
18. If yes, when was your diabetes first noted? _____
19. Has your voice deepened? (*circle one*) YES NO

20. Do you have any discharge from your nipples? (*circle one*) YES NO

21. List all medications you are using now or have used in the last 6 months for any reason?

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |