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Health History

Today's Date: ____________

Please help me to provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in blue or black ink.

Name: ____ Sex: ____ Height: _____ Weight: _____

Age: ____ Date of Birth: ____/____/____

Address: ____________________________________ City: ____________ State:________ Zip: _________

Preferred Phone Number: ___________________________ Email: ___________________________________

I am (circle one): Single / Married / Divorced / Widowed / Partnered

Occupation: Referred by:

Emergency Contact Name: Phone: Relation:

Primary Care Physician: ____

Address: ____ Phone: ____________________

Fax: _____________________________ Date of most recent physical examination: _____/______
Date of most recent pelvic exam & pap smear: ____ / ____

Are you currently pregnant or trying to become pregnant? YES, currently / YES, trying / NO

Are you currently breastfeeding? YES / NO Do you have a pacemaker? YES / NO

MEDICATIONS AND SUPPLEMENTS: Please list ALL prescription and over-the-counter medications, as well as herbs, vitamins, and other nutritional supplements. Include dosage, condition treated, and prescriber.

MEDICATION/SUPPLEMENT	DAILY DOSE	CONDITION TREATED	PRESCRIBED BY:

ALLERGIES: Underline if reaction is severe or requires emergency care. Write "NKA" if none are known.

Drugs/medications: ____

Foods: ____

Environmental/Seasonal/Chemical/Other: ____

MAJOR HOSPITALIZATIONS / ILLNESSES (exclude normal pregnancies):

DATE	HOSPITALIZATION / ILLNESS	TREATMENT(S) (surgery?)

FAMILY HISTORY
Complete for each family member, indicating any of the illnesses that they have ever had. Place an "X" in the appropriate box(es)

	SELF	MOTHER	FATHER	SIBLING(S)	CHILD(REN)	GRANDPARENT(S)
Cancer or tumors						
Diabetes						
Bleeding disorder						
Seizures						
High Blood Pressure						
Heart disease / heart attack						
Stroke						
Asthma / Allergies						
Addiction(s)						
Mental illness						
Autoimmune disease						
Thyroid disease						
Kidney disease						
High cholesterol						
Other:						

LIFESTYLE: Please indicate how much, how many, or how often you consume:

Water (8 oz. cups): ____ Soda (8 oz. cups): ____ Coffee/Tea (8 oz. cups): ____ Alcohol (drinks per week): ____

Cigarettes (packs per week): ____ Marijuana / other recreational drugs (specify): ______________________

Dietary restrictions (vegetarian, vegan, intolerances): ____

What do you eat on a typical day?

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Exercise (type, frequency, duration): ____

What activities do you enjoy doing in your free time? ____

GYNECOLOGICAL HISTORY:

Please list any gynecological diagnoses you may have received, with dates and treatment(s) received.

Diagnosis: Date(s): Treatment(s):

Age of first menses: ______

Date of most recent menstrual period: ____/____/_____

Menses usually last(ed) for _____ days.

Menstrual cycle is (was) _____ days long.

Cycle is (was): REGULAR / IRREGULAR.

Menopause onset: ____ / _______

Please circle all that apply. (Menopausal women please underline menstrual history symptoms).

Menses:
Pain before period (where? ____________________)
Pain during period (where? ____________________)
Pain after period (where? ______________________)
Clots in menses
Pale/pink menses
Dark red menses
Purple / black menses
Brown menses
Mucus in menses
Heavy flow
Light flow
Flow stops and starts
Postmenopausal bleeding
Other:

PMS:
Breast tenderness / swelling
Fatigue
Easy to cry / sadness
Irritability
Mood swings
Increased/decreased productivity/creativity
Increased/decreased libido
Headaches
Insomnia / nightmares
Food cravings
Increased/ decreased appetite
Bloating
Nausea / vomiting
Acne
Other:

Current method(s) of contraception: ____

Past method(s) of contraception: ____

Number of pregnancies: ____ live births: ____ miscarriages: ____ abortions: ____

Describe any pregnancy/birth/postpartum complications or difficulties:

Please list any recent hormonal or endocrine testing results:

SYMPTOM OVERVIEW: CIRCLE current conditions and UNDERLINE those you have had in the past.

General:
Fatigue
Recent weight loss/gain
Unusual sweating
Chills
Fever
Hot flashes
Strongly prefer cold drinks
Strongly prefer hot drinks
Cold / Hot hands
Cold / Hot feet

Head & Neck:
Headaches
Migraines
Stiff neck
Dizziness
Fainting
Swollen glands

Ears:
Hearing aids
Hearing loss
Ringing / Tinnitus
Frequent Infections
Earache
Vertigo

Eyes:
Glasses / Contact lenses
Blurred or double vision
Poor night vision
Spots or floaters
Eye inflammation
Glaucoma
Cataracts
Dryness
Dislike bright light

Nose, Throat & Mouth
Sinus infection
Nasal discharge / congestion
Postnasal drip
Frequent sore throat
Difficulty swallowing
Mouth or tongue ulcers
Frequent colds
Nosebleeds
Dry mouth/throat
Loss of voice
Thirst
Jaw pain or clicking
Facial pain
Tooth / Gum problems

Skin, Hair, Nails:
Hives / Rashes
Eczema
Psoriasis
Dry skin
Oily skin
Easy bruising
Changes in moles, lumps
Itchiness
Acne
Brittle/dry hair
Brittle/dry nails

Respiratory
Difficulty breathing
Wheezing / Asthma
Chronic cough
Coughing up phlegm
Coughing up blood
Shortness of breath
Frequent sighing

Cardiovascular
High blood pressure
Low blood pressure
High cholesterol
Chest pain or tightness
Palpitations
Rapid heart beat
Irregular heart beat
Poor circulation
Swollen ankles
Anemia
History of heart attack

Gastrointestinal
Antacid use
Laxative use
Poor appetite
Excessive hunger
Weight loss / weight gain
Nausea or Vomiting
Indigestion
Stomach pain
Diarrhea
Constipation
Gas / Flatulence
Hiccups
Acid regurgitation
Bloating
Bad breath
Bloody stool
Mucus in stool
Hemorrhoids

Musculoskeletal:
Sore / weak muscles
Arthritis
Neck/shoulder pain
Upper back pain
Lower back pain
Weak/sore knees
Weak/sore ankles
Ribcage pain
Limited range of motion

Neurological / Psychological
Seizures
Tremors
Numbness or tingling
Paralysis
Poor coordination
Insomnia
Disturbing dreams / Nightmares
Irritability / Anger
Depression
Self-injury / Cutting
Suicidal thoughts
Anxiety
Mood swings
Poor memory
Obsessive thinking
Low motivation
Fearfulness

Genito-urinary
Pain on urination
Frequent urination
Urgent urination
Blood in urine
Incontinence
Incomplete urination
Frequent night waking to urinate
Urinary tract infection
Kidney stones
Increased libido
Decreased libido
Painful intercourse
Fibrocystic breasts
Pain/itching of genitalia
Genital infection / STI
Vaginal yeast infection
Vaginal discharge