

Name \_\_\_\_\_ Nickname (If preferred) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Age \_\_\_\_\_ Female / Male Current weight \_\_\_\_\_ one year ago \_\_\_\_\_ Maximum weight \_\_\_\_\_ Height \_\_\_\_\_

Drug allergies \_\_\_\_\_

**Reasons for this visit-** please include your most important health concerns in order of significance:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List ALL Prescription and non-prescription oral, nasal, inhaled and topical medications with dosages** as you ACTUALLY take them (250mg once daily, 100mg twice weekly, 2-3 10mg tablets 3 days a month as needed for pain/headaches, etc) **Please include medications** like Tylenol, Ibuprofen, Aspirin, Miralax, Nasal Sprays (Nasacort, Flonase, isotonic saline) skin creams/ointments/gels with the name and percentage of the active ingredient, even if you only use them occasionally. If you run out of space or time or do not understand the labeling - bring all medications with you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List ALL** supplements, herbs, vitamins, minerals, homeopathics, protein/fiber/green powders as you ACTUALLY take them. For complex formulas (more than 2 ingredients), include the BRAND and product name or bring the bottle with you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle any of the following that you use:

Coffee/black tea/cola \_\_\_\_\_ /day/wk/mo Milk(type \_\_\_\_\_) Sweetener (type \_\_\_\_\_) Flavoring(type \_\_\_\_\_)

Alcohol \_\_\_\_\_/day/wk/mo Wine/Beer/Spirits Recreational drugs \_\_\_\_\_ day/wk/mo (type \_\_\_\_\_ # years \_\_\_\_\_)

Nicotine \_\_\_\_\_/day/wk/mo Cigarettes/Nicotine gum/Patch ( \_\_\_\_\_#/day) Total # years of cigarette smoking \_\_\_\_\_

Dietary regimens or restrictions : gluten-free/wheat-free/dairy-free/vegetarian/vegan \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Food allergies, sensitivities, diagnosed or suspected: \_\_\_\_\_

Exercise regularly: **Yes No** Types: \_\_\_\_\_

How often? \_\_\_\_\_ For how long? \_\_\_\_\_

**CIRCLE** symptoms you experience regularly. **Women: X CHECK** if they occur near or with your period where applicable.

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> Irritability/anger                         | <input type="checkbox"/> Fatigue               | <input type="checkbox"/> Moodiness   | <input type="checkbox"/> Anxiety/depression                                      | <input type="checkbox"/> Difficulty concentrating   |
| <input type="checkbox"/> Oversensitivity                            | <input type="checkbox"/> Cry easily            | <input type="checkbox"/> Memory problems   | <input type="checkbox"/> Cravings : <input type="checkbox"/> sweets              | <input type="checkbox"/> Bread <input type="checkbox"/> salt <input type="checkbox"/> carbs |
| <input type="checkbox"/> Breast tenderness                          | <input type="checkbox"/> Nausea                | <input type="checkbox"/> Increased appetite  | <input type="checkbox"/> chocolate <input type="checkbox"/> coffee               | <input type="checkbox"/> Alcohol <input type="checkbox"/> other _____                       |
| <input type="checkbox"/> Low back pain                              | <input type="checkbox"/> Acne                  | <input type="checkbox"/> Lowered appetite  | <input type="checkbox"/> Weight gain   | <input type="checkbox"/> Difficult to lose weight   |
| <input type="checkbox"/> Pelvic cramping                            | <input type="checkbox"/> Joint pain            | <input type="checkbox"/> Muscle aches/pain   | <input type="checkbox"/> Weight loss   | <input type="checkbox"/> Difficult to gain weight   |
| <input type="checkbox"/> Foot/Calf cramps                           | <input type="checkbox"/> Pins/needles          | <input type="checkbox"/> Stiff muscles   | <input type="checkbox"/> Restless legs   | <input type="checkbox"/> Numbness   |
| <input type="checkbox"/> Acid reflux/heart-burn/indigestion/burping | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Sinus congestion/ runny nose/ regardless of season _____? | <input type="checkbox"/> Abdominal bloating                                      | <input type="checkbox"/> Water retention:   |
| <input type="checkbox"/> Bowel irregularity                         | <input type="checkbox"/> Migraines             | <input type="checkbox"/> Constipation  | <input type="checkbox"/> Gas/Flatulence  | <input type="checkbox"/> in hands   |
| <input type="checkbox"/> Hair thinning                              | <input type="checkbox"/> Neck pain             | <input type="checkbox"/> Can't fall asleep   | <input type="checkbox"/> Abdominal discomfort                                    | <input type="checkbox"/> in legs/ankles/feet  |
| <input type="checkbox"/> Low sex drive                              | <input type="checkbox"/> Hemorrhoids           | <input type="checkbox"/> Dark facial hair  | <input type="checkbox"/> Diarrhea/loose stool                                    | <input type="checkbox"/> Light colored stool  |
| <input type="checkbox"/> Heart palpitations                         | <input type="checkbox"/> Insomnia              | <input type="checkbox"/> Chest congestion  | <input type="checkbox"/> Can't stay asleep                                       | <input type="checkbox"/> Night sweats   |
| <input type="checkbox"/> Cough/phlegm                               | <input type="checkbox"/> No sex drive          | <input type="checkbox"/> Choking   | <input type="checkbox"/> Infertility   | <input type="checkbox"/> Hot flashes  |
| <input type="checkbox"/> Often clearing throat                      | <input type="checkbox"/> Wheezing              | <input type="checkbox"/> Hives/itching   | <input type="checkbox"/> Bladder infections                                      | <input type="checkbox"/> Vaginal dryness/itching/burning                                    |
| <input type="checkbox"/> Plugged ears/itchy ear ringing/buzzing     | <input type="checkbox"/> Sore throat           | <input type="checkbox"/> Chronic Rash  | <input type="checkbox"/> Urinary incontinence                                    | <input type="checkbox"/> Pain during sex  |
| <input type="checkbox"/> Room goes dark                             | <input type="checkbox"/> Vomiting              | <input type="checkbox"/> Sneezing attacks  | <input type="checkbox"/> Yeast infections  | <input type="checkbox"/> Bladder infections/irritation after sex                            |
| <input type="checkbox"/> Excessive sweating                         | <input type="checkbox"/> Vertigo               | <input type="checkbox"/> Sluggish/lethargy   | <input type="checkbox"/> Bacterial vaginosis                                     | <input type="checkbox"/> Erectile dysfunction/poor sexual stamina                           |
|   | <input type="checkbox"/> Room spins            | <input type="checkbox"/> Chest pain  | <input type="checkbox"/> Cold sores/canker sores                                 |   |
|   | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Shortness of breath                                       | <input type="checkbox"/> Frequent colds/flu                                      |   |
|   | <input type="checkbox"/> Watery/itchy dry eyes |  | <input type="checkbox"/> I catch everything going around the office/school/house |   |

**Sleep Hygiene:** Use of sleep aid? **Yes No** Type \_\_\_\_\_ How often? \_\_\_\_\_

(If you use a sleep aid, please fill out according to how you sleep **with** a sleep aid, then explain in space below how you sleep **without** an aid)

# of hours per night of actual sleep on weekdays \_\_\_\_\_ on weekends \_\_\_\_\_ # of hours ALLOWED for sleep on

Weekdays \_\_\_\_\_ on Weekends \_\_\_\_\_ How long does it take to fall asleep? \_\_\_\_\_ Wake during the night? **Yes No**

Approx. # of times \_\_\_\_\_ How long awake during these times? Approx. \_\_\_\_\_ # of times night sweats

wake you up \_\_\_\_\_ #of times you wake needing to urinate \_\_\_\_\_ I only wake up from: family/pets/noise

How is your sleep **without** an aid: \_\_\_\_\_

Use of (Circle) **TV/Computer/iPAD/Messaging device** before bed or when trying to go to sleep

Room completely dark when going to sleep (circle: street lights, floodlights, nightlights, clock lights)? **Yes No**

Wear an eye mask/earplugs? **Yes No** What time do you go to bed? \_\_\_\_\_ What time do you get up? \_\_\_\_\_

**Menstrual and Reproductive History:** (This page, females only)

Age of first period\_\_\_ Using a birth control method now? **Yes No** Type?\_\_\_\_\_

Trying to get pregnant? **Yes No** #of pregnancies\_\_\_ #of miscarriages\_\_\_ #of abortions \_\_\_ #of cesareans\_\_\_

#of ectopic/tubal pregnancies\_\_\_ #of stillbirths\_\_\_ #premature deliveries \_\_\_ #of living children\_\_\_ Ages\_\_\_\_\_

**What birth control have you used:** circle type used in the past, add year and duration: Pill\_\_\_\_\_ Depo shot\_\_\_\_\_

IUD (Mirena/other \_\_\_\_\_) \_\_\_\_\_ Patch \_\_\_\_\_ Vaginal ring \_\_\_\_\_ Emergency contraception \_\_\_\_\_

Problems with any of the methods? **Yes No** If yes, please explain?\_\_\_\_\_

Current or past fertility treatment? **Yes No** Past use of **bioidentical hormones?** circle all that apply, add year/duration

DHEA\_\_\_\_\_ Biest \_\_\_\_\_ Estradiol \_\_\_\_\_ Estriol \_\_\_\_\_

Progesterone \_\_\_\_\_ Pregnenolone \_\_\_\_\_ Testosterone \_\_\_\_\_

Have you had a hysterectomy? **Yes No** Date \_\_\_\_\_ Reason? \_\_\_\_\_

Do you still have ovaries? **None One Two** Uterine Ablation? **Yes No** Date \_\_\_\_\_

**Circle all that apply**, current and past: Fibrocystic breasts Breast cancer Osteoporosis/Osteopenia Lichen Sclerosis

Uterine fibroids Endometrial hyperplasia Endometriosis Ovarian cysts PCOS (polycystic ovarian syndrome)

Vaginal yeast infections Bacterial vaginosis Gonorrhoea Chlamydia Trichomonas Genital herpes Genital warts

Last PAP \_\_\_\_\_ Dates of abnormal results: \_\_\_\_\_ Dates of treatment \_\_\_\_\_

History of HPV ? **Yes No** Type \_\_\_\_\_ HPV Vaccine? (Gardasil) **Yes No**

For other **PMS or menstrual related symptoms** not listed or **other unique symptoms**, please list them here: \_\_\_\_\_

**Menstrual details:** Last menstrual period (date of first day of bleeding) \_\_\_\_\_ or **# of years since last period** \_\_\_\_\_

Tubal ligation? **Yes No** Date \_\_\_\_\_ how many days is your current cycle? (count from the 1st day of bleeding to

the 1st day of bleeding of the next cycle) **circle: <20 20-30 30-40 40-50 >50** Is your cycle predictable? **Yes no**

How many days do you bleed? \_\_\_\_\_ How many heavy days of bleeding? \_\_\_\_\_ # of **tampons and/or pads (circle)**

on heavy days \_\_\_\_\_/\_\_\_\_\_ on light days \_\_\_\_\_/\_\_\_\_\_

Color of flow: Bright red Dark red Light red Pink Brown **Spotting only (circle)** Do you pass **clots?** **Yes No**

Size of clots(circle): grainy pea nickel quarter golfball egg lemon How many days do you pass clots? \_\_\_\_\_

**Medical History:**

Surgeries, hospitalizations, Emergency room visits and other procedures(include approximate dates and chronology):

Last: Colonoscopy \_\_\_\_\_ Prostate exam \_\_\_\_\_ Mammogram \_\_\_\_\_ DEXA \_\_\_\_\_ EKG \_\_\_\_\_

\_\_\_\_\_

**Current Medical diagnoses:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Personal medical history and Family medical history (blood relatives only):**

|                          | Self  | Past | Family | Relation to you |                          | Self  | Past      | Family | Relation |
|--------------------------|-------|------|--------|-----------------|--------------------------|-------|-----------|--------|----------|
| Alcoholism/drug use      | ___   | ___  | ___    | _____           | Anemia                   | ___   | ___       | ___    | _____    |
| Asthma                   | ___   | ___  | ___    | _____           | Allergies                | ___   | ___       | ___    | _____    |
| Arthritis                | ___   | ___  | ___    | _____           | Auto-immune disorder     | ___   | ___       | ___    | _____    |
| Bladder disease          | ___   | ___  | ___    | _____           | (type _____)             | ___   | ___       | ___    | _____    |
| Cancer                   | ___   | ___  | ___    | _____           | Celiac disease           | ___   | ___       | ___    | _____    |
| (types _____)            |       |      |        |                 | Crohn's/Colitis          | ___   | ___       | ___    | _____    |
| Depression               | ___   | ___  | ___    | _____           | Diabetes (Type 1 type 2) | ___   | ___       | ___    | _____    |
| Diverticulosis/itis      | ___   | ___  | ___    | _____           | Epilepsy/Seizures        | ___   | ___       | ___    | _____    |
| Gall stones/disease      | ___   | ___  | ___    | _____           | Gum disease              | ___   | ___       | ___    | _____    |
| Heart Disease            | ___   | ___  | ___    | _____           | High blood pressure      | ___   | ___       | ___    | _____    |
| Hepatitis A B C (circle) | ___   | ___  | ___    | _____           | Kidney disease/stones    | ___   | ___       | ___    | _____    |
| Lung disease             | ___   | ___  | ___    | _____           | Liver disease            | ___   | ___       | ___    | _____    |
| Mental disorder          | ___   | ___  | ___    | _____           | Mononucleosis/EBV        | ___   | ___       | ___    | _____    |
| (type _____)             |       |      |        |                 | Obesity                  | ___   | ___       | ___    | _____    |
| Rheumatic fever          | ___   | ___  | ___    | _____           | Stroke                   | ___   | ___       | ___    | _____    |
| Suicide attempt(s)       | #     | ___  | ___    | _____           | Thyroid disease          | ___   | ___       | ___    | _____    |
| Date(s)                  | _____ |      |        |                 | Tuberculosis             | ___   | ___       | ___    | _____    |
| Tumor                    | ___   | ___  | ___    | _____           | Tumor discovery date     | _____ | Treatment | _____  | _____    |

Other personal and family medical history not listed or previously stated \_\_\_\_\_

\_\_\_\_\_

Last dental exam \_\_\_\_\_ How often do you: Floss \_\_\_\_\_? See the dentist? \_\_\_\_\_ Metal fillings? **Yes No**

Gingivitis/periodontal disease? **Yes No** Root canals? **Yes No** # \_\_\_\_\_ Other \_\_\_\_\_

Immunizations: (circle) DTaP MMR Polio Varicella "Flu" (last \_\_\_\_\_) Hepatitis B Hib Pneumococcal Other \_\_\_\_\_

Additional information: \_\_\_\_\_

\_\_\_\_\_