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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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.

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**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.

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

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

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

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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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| \_\_Irritability/anger \_\_Fatigue | | \_\_Moodiness | \_\_Anxiety/depression | \_\_Difficulty concentrating |  |
| \_\_Oversensitivity \_\_Cry easily | | \_\_Memory problems | \_\_Cravings : \_\_sweets | \_\_Bread \_\_salt \_\_carbs |  |
| \_\_ Breast tenderness \_\_Nausea | | \_\_Increased appetite | \_\_ chocolate \_\_coffee | \_\_Alcohol \_\_ other\_\_\_\_\_ |  |
| \_\_Low back pain \_\_Acne | | \_\_Lowered appetite | \_\_Weight gain | \_\_Difficult to lose weight |  |
| \_\_ Pelvic cramping \_\_Joint pain  \_\_Foot/Calf cramps \_\_Pins/needles | | \_\_Muscle aches/pain \_\_Stiff muscles | \_\_Weight loss  \_\_Restless legs | \_\_Difficult to gain weight \_\_Numbness |  |
| \_\_Acid reflux/heart- \_\_Headaches | | \_\_Sinus congestion/ runny nose/ regard- less of season \_\_\_\_? | \_\_Abdominal bloating  \_\_ Gas/Flatulence  \_\_Abdominal discomfort | \_\_Water retention:  \_\_ in hands  \_\_ in legs/ankles/feet |  |
| burn/indigestion/ burping | \_\_Migraines  \_\_Neck pain |  |
| \_\_Bowel irregularity | \_\_Hemorrhoids | \_\_Constipation | \_\_ Diarrhea/loose stool | \_\_ Light colored stool |  |
| \_\_ Hair thinning  \_\_ Low sex drive | \_\_Insomnia  \_\_No sex drive | \_\_Can’t fall asleep  \_\_ Dark facial hair | \_\_Can’t stay asleep  \_\_ Infertility | \_\_Night sweats  \_\_Hot flashes |  |
| \_\_Heart palpitations \_\_Cough/phlegm | \_\_Wheezing  \_\_Sore throat | \_\_Chest congestion \_\_Choking | \_\_Bladder infections  \_\_Urinary incontinence | \_\_Vaginal dryness/ itching/burning |  |
| \_\_Often clearing throat \_\_Plugged ears/itchy ear ringing/buzzing \_\_Room goes dark  \_\_Excessive sweating | \_\_Vomiting  \_\_Vertigo  \_\_Room spins  \_\_Fainting  \_\_Watery/itchy dry eyes | \_\_Hives/itching  \_\_Chronic Rash  \_\_Sneezing attacks  \_\_Sluggish/lethargy  \_\_Chest pain  \_\_Shortness of  breath | \_\_Yeast infections  \_\_Bacterial vaginosis  \_\_Cold sores/canker sores  \_\_ Frequent colds/flus  \_\_ I catch everything going around the office/school/house | \_\_ Pain during sex  \_\_ Bladder infections/ irritation after sex \_\_Erectile dysfunction/ poor sexual stamina |  |

**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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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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 Gonorrhea 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\_\_\_\_\_\_\_\_\_\_\_

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**Current Medical diagnoses**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 \_\_\_ \_\_\_ \_\_\_ \_\_\_\_\_\_\_\_\_\_ Mononucelosis/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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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