

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/ regard-less of season ____? | <input type="checkbox"/> Abdominal bloating | <input type="checkbox"/> Water retention: |
| <input type="checkbox"/> Bowel irregularity | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas/Flatulence | <input type="checkbox"/> in hands |
| <input type="checkbox"/> Hair thinning | <input type="checkbox"/> Hemorrhoids | <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"/> Insomnia | <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"/> No sex drive | <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"/> Wheezing | <input type="checkbox"/> Choking | <input type="checkbox"/> Infertility | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Often clearing throat | <input type="checkbox"/> Sore throat | <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"/> Vomiting | <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"/> Vertigo | <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"/> Room spins | <input type="checkbox"/> Sluggish/lethargy | <input type="checkbox"/> Bacterial vaginosis | <input type="checkbox"/> Erectile dysfunction/poor sexual stamina |
| | <input type="checkbox"/> Fainting | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Cold sores/canker sores | |
| | <input type="checkbox"/> Watery/itchy dry eyes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Frequent colds/flu | |
| | | | <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: _____
