FEMALE HISTORY

GENERAL INFORMATION

Name _____ Today's Date _____
Address _____ City _____ State _____ Zip _____
Age _____ DOB _____ Height _____ Weight _____ Phone _____ Email _____

SPECIFIC COMPLAINTS/CONCERNS/SYMPTOMS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note when they started, how often they occur, and their severity.

Problem	When did it start?	How often?	How severe is it?
1. e.g. Headaches	June 2009	3 times per week	mild/moderate/severe
2.			
3.			
4.			
5.			
6.			
7.			

GENERAL SYMPTOMS

Symptom	Mild	Moderate	Severe	Comments
Body/joint aches				
Weight gain				
Weight loss				
Elevated blood pressure				
Elevated cholesterol				
Digestive problems				
Head hair loss				
Dry or thinning skin				
Constant hunger				
Sweet cravings				
Caffeine cravings				
Salt cravings				
Anger or aggression				
Irritability				
Low mood/depression				
Concentration problems				
Foggy thinking				
Increased fatigue				
Lowered labido				
Menstrual problems				
Frequent need to urinate				
Pain with urination				
Bone loss/osteoporosis				
Low blood sugar				
Other				

FEMALE HISTORY 2

MEDICATIONS AND SUPPLEMENTS

Please list all medications that you are taking or have taken in the last month, including prescription drugs, non-prescription drugs, antibiotics, vitamins, minerals and nutritional supplements: (use back if necessary)

Medication or Supplement	Dosage	Any Side Effects?

ALLERGIES

Medication/Supplement/Food/Animal/Environmental	Reaction

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes No If yes, please list:

_____

_____

_____

_____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes No
If yes, which kind: _____ How many? _____
How long have you had these fillings? _____
If you don't have any fillings have you had any removed in the last 12 months? Yes No
Have you had any other dental work done in the last 12 months? Yes No What? _____

SLEEP/REST

Average number of hours you sleep >10 8 – 10 6 – 8 <6
Do you have trouble falling asleep? Yes No
Do you get a second wind at night? Yes No
Do you have problems with insomnia? Yes No
Do you feel rested upon awakening? Yes No
Do you snore? Yes No
Do you use sleeping aids? Yes No What kind? _____ How often? _____

FEMALE HISTORY 3

LIFESTYLE INDICATORS

Tobacco Intake

Currently using tobacco: No Yes Cigarettes Smokeless Cigar Pipe Patch/Gum Snuff/Chew
How long? _____ How often? _____ How much? _____
Previous smoking? How many years? _____ Packs per day: _____ How long ago: _____
Are you exposed to second hand smoke? If yes, please explain: _____

Alcohol Intake

How many drinks currently per week? (1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)
None _____ 1-3 _____ 4-6 _____ 7-10 _____ >10 _____
Previous alcohol intake? Yes ____ (Mild _____ Moderate _____ High _____)

Caffeine Intake

How many cups of coffee per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____
How many cans of soda per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____ Diet soda? Yes No

EXERCISE

How often do you exercise? Once a month or less Once a week or less Weekly 2x 3x 4x+
Do you: Walk Run Lift Weights Yoga Golf or other sports Martial Arts Other _____
Average length of your workout _____

PREGNANCY HISTORY

ARE YOU CURRENTLY PREGNANT? Yes No Breastfeeding? Yes No Please indicate the number of the following:
Pregnancies _____ Miscarriage _____ Abortion _____ Vaginal deliveries _____ Caesarean _____
Living children _____ Post partum depression Toxemia Gestational diabetes Baby over 8 lbs

FOR THE CYCLIC-AGE WOMAN

Age at first period:_____ Frequency: _____ Length of period: _____ Pain: Yes No Clotting: Yes No
Period skipped? Yes No For how long? _____ Last Period: _____ Length of current cycle _____
Have you ever used hormonal contraception? Yes No If yes, when _____
What kind? The pill Patch/Injection Nuva Ring Did taking the pill agree with you? Yes No
Use other contraception? Yes No What type? Condom Diaphragm IUD Partner vasectomy
Late in your cycle, do you have breast tenderness, water retention, or irritability (PMS)? Yes No
Date of last Mammogram _____ Breast Biopsy/Date _____
Last PAP Test: _____ Normal _____ Abnormal _____

FOR THE WOMAN IN MENOPAUSE

Are you currently in menopause? Yes No Year of onset _____
When you were cycling was your cycle regular? Yes No If no, why? _____
When you were cycling, what was your typical menstrual flow? Light Medium Heavy
Have you had a hysterectomy? Complete (ovaries and uterus) Partial (uterus only)
Date of hysterectomy _____ Reason for hysterectomy: _____
Date of last Mammogram _____ Breast Biopsy/Date _____
Date of last Bone Density _____ Results: High Low Within normal range
Do you take: Estrogen Ogen Estrace Premarin Progesterone Provera Other _____
How long have you been on hormone replacement? _____
Other information for us to know: _____

Healthy Happy You