



General Health History Questionnaire

(To be completed by patient)

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M / F (circle one)

Weight: _____ Height: _____

Chief Complaint(s):

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

- | | |
|---|---|
| <input type="checkbox"/> Antacids, Zantac, Pepcid AC, Roloids, etc. | <input type="checkbox"/> Relaxants/Sleeping Pills |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Radiation |
| <input type="checkbox"/> Ulcer Medications | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Antibiotic/Antifungal | <input type="checkbox"/> Aspirin/Acetaminophen |
| <input type="checkbox"/> Anti-diabetic/Insulin | <input type="checkbox"/> Cortisone/Anti-Inflammatory |
| <input type="checkbox"/> Oral Contraceptives | <input type="checkbox"/> Heart Medications |
| <input type="checkbox"/> Hormones – If so, what? _____ | <input type="checkbox"/> High Blood Pressure Medicine |
| When? _____ | Dosage? _____ |

Please list names of any medications you are currently taking:

Are you allergic to any drugs that you know of? (if so please list names):

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking:

Lifestyle

Dietary Habits: Describe the foods you normally eat:

BREAKFAST: _____

LUNCH: _____

DINNER: _____

SNACKS: _____

Do you consume the following?

If so, how much?

- | | | | |
|---|-----|----|-------|
| 1. Soda or carbonated beverages? | YES | NO | _____ |
| 2. White flour products? | YES | NO | _____ |
| 3. Fried foods? | YES | NO | _____ |
| 4. Coffee? | YES | NO | _____ |
| 5. Fast foods regularly? | YES | NO | _____ |
| 6. Sweets and/or refined carbohydrates? | YES | NO | _____ |
| 7. Alcoholic beverages? | YES | NO | _____ |
| 8. Any tobacco products? | YES | NO | _____ |

Are you a vegetarian? YES NO

Are you currently involved in an exercise program? YES NO How often? _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How do you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

Males Only

Have you had a vasectomy? YES NO When? _____

Reverse vasectomy? YES NO When? _____

Experienced any symptoms related to the vasectomy? YES NO

If so, please explain: _____

Do you have any history of prostate problems? YES NO

If so, please explain: _____

When was your last prostate exam? _____

What were your most recent PSA results? _____ Date _____

- | | | | |
|---|-----|----|-----------|
| Does your bladder always feel full? | YES | NO | SOMETIMES |
| Do you experience inconsistent pressure or pain during urination? | YES | NO | SOMETIMES |
| Does ejaculation cause pain? | YES | NO | SOMETIMES |
| Do you experience low sex drive? | YES | NO | SOMETIMES |
| Do you have premature ejaculation? | YES | NO | SOMETIMES |

All men completing this form should now skip to the bottom section of page 6 labeled "sleep" and continue on with the remainder of this questionnaire.

Females Only – Reproductive Health History (to be completed by all women)

Age at onset of first period: _____ Approximate date of onset: _____

What are you using for contraception at the moment? _____

Have you ever used **oral, injected, patch, or ring** hormone contraceptives, or used *Emergency Contraception* (“the day after” pill)? YES NO

From _____ to _____

Did you suffer from any side effects? YES NO Explain: _____

Are you currently or have you ever used an IUD? YES NO

When? _____ For how long? _____

While under the use of any and all birth control methods, did you experience the following? *Yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.* **(Please circle and use extra space provided if explanation is needed)**

Are you currently, or have you ever used fertility treatment? YES NO

If yes, please explain. _____

Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc.? YES NO

If yes, what hormone(s), dosage and for how long? **Please be specific with dates of use.**

Do you have any history of abnormal Pap Tests? YES NO

If yes, please explain: _____

Please describe any treatment and/or medication for this: _____

Do you have any history of vaginal infections? YES NO

If yes, please describe: _____

Please describe any treatment and/or medication for this: _____

Do you have any history of the following conditions? *(Please circle appropriate answer)*
Ovarian Cysts, Fibrocystic Breasts, Polycystic Ovarian Syndrome (PCOS), Uterine Fibroids,
Endometriosis, Lichen Sclerosis, Vulvodynia

Pregnancy History (to be completed by all women, if applicable)

Have you been pregnant before? YES NO

Please list the age(s) of your children:

Please explain important details/complications below:

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

How many weeks gestation at the time of miscarry? _____ Weeks

Number of premature births: _____

Number of cesarean births: _____

Number of stillbirths: _____

Number of ectopic pregnancies: _____

All menopausal women should now skip to the bottom section of page 5 labeled "menopausal women" and continue on with the remainder of this questionnaire.

Cycling History (to be completed by all women who have not reached menopause)

What was the first date of your last menstrual period (LMP)? _____

Have you ever had tubal ligation surgery? YES NO

If so, please list the date and specific details: _____

Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle? (Please circle appropriate answer)

<20 days 20-30 days 30-40 days 40-50 days >50 days

What is the length of days your menstruation typically lasts? _____

Do you consider your cycle to be regular? YES NO Not Always

Details: _____

What is your typical menstrual flow like? Light Medium Heavy

Details: _____

How many pads and/or tampons (circle) do you use on heavy days? _____

During menstruation, do you pass blood clots? YES NO How often? _____

How would you describe your cramping? None Mild Moderate Severe

At what point in your cycle? _____

Cycling History, Cont'd (to be completed by all women who have not reached menopause)

Have you noticed any recent changes to your cycle? If yes, explain: _____

During menstruation do you experience any vaginal discharge? YES NO
When? _____

Do you ever experience itching or odor in the vaginal area? YES NO
When? _____

Do you experience any breast tenderness? None Mild Moderate Severe
If yes, at what point in your cycle? _____

Do you have nipple discharge at any point in your cycle? YES NO
If yes, at what point in your cycle? _____ Color? _____

All cycling women should now skip to the bottom section of page 6 labeled "sleep" and continue on with the remainder of this questionnaire.

Menopausal Women

What age were you at the onset of menopause? _____ Year of onset? _____

Please describe any recent changes and/or symptoms associated with your cycle:

Please list any and all GYN surgeries:	What was the reason for each surgery?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Please give an in depth explanation of how you perceive your experience transitioning into menopause: (for example, please list symptoms, emotional changes, thoughts, stressors, etc.)

Are you currently, or have you ever used conventional hormone replacement (HRT)? _____
If yes, please list the name of the prescription: _____
What is/was the dosage? _____ For how long? _____

Menopausal Women Continued...

Are you currently, or have you ever used bio-identical hormone creams/gels/sublingual, troche, oral? YES NO

If yes, please list the name(s) of each product: _____

What is/was the dosage? _____ For how long? _____

Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? YES NO

If yes, please list the name(s) of each product: _____

What is/was the dosage? _____ For how long? _____

Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? YES NO

If yes, what? _____

Treatment: _____

Below please describe your cycle history.

Would you have described your menstruation as: Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling would you describe your cycle as regular? YES NO

If no, please give explanation: _____

In the past, if you have ever received any type of "treatment" for any cycle issues would you please explain: _____

Sleep

How well do you sleep?

Well Trouble falling asleep Trouble staying asleep Insomnia

What is the average number of hours you most often sleep each night? _____

Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO

If yes, how often? _____

Do you keep your room completely dark at night? YES NO

Signs & Symptoms (INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.

Section 1:

Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestion?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/Nausea? (circle)	1	2	3

Section 2:

Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
IBS?	1	2	3
Persistent Gas?	1	2	3
Digestive problems?	1	2	3

Section 3:

Low blood sugar / hypoglycemia?	1	2	3
Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine/stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

Section 4:

Low mood/depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

Signs & Symptoms, Cont'd (INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.

Section 5:

Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships? (circle)	1	2	3
Decreased initiative/motivation/drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness/crying? (circle)	1	2	3

Section 7:

Decrease in strength/stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decreased lean muscle mass?	1	2	3
Muscle soreness/weakness? (circle)	1	2	3
Body/joint aches? (circle)	1	2	3
Increased fat on hips/breasts/thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/Migraines? (circle)	1	2	3
Muscle pain/Joint aches/Backache? (circle)	1	2	3

Section 9:

Head hair loss/body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Signs & Symptoms, Cont'd (INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.

Section 10: (females only)

Infertility?	1	2	3
Lowered/Heightened libido? (circle)	1	2	3
Hot flashes?	1	2	3
Night sweats?	1	2	3
Palpitations?	1	2	3
Breast tenderness?	1	2	3
Breast cysts?	1	2	3
Vaginal infections/Yeast infections? (circle)	1	2	3
Urinary Frequency/Incontinence/Infections? (circle)	1	2	3
Changes to labia/clitoral tissue (Atrophy, thinning, discoloration, itching, burning)? (circle)	1	2	3
Vaginal changes (dryness, tearing, decreasing size)? (circle)	1	2	3
Bone loss/osteoporosis?	1	2	3
Endometriosis?	1	2	3
Pelvic Inflammatory Disease?	1	2	3
Cystitis?	1	2	3
Ovarian cysts?	1	2	3
Fibroids?	1	2	3

Section 11: (males only)

Lowered libido?	1	2	3
Erectile Dysfunction (ED)?	1	2	3
Pain w/ ejaculation?	1	2	3
Frequent need to urinate?	1	2	3
Urination is delayed/strained/incomplete? (circle)	1	2	3
Pain with urination?	1	2	3
Blood in the urine?	1	2	3
Bone loss/osteoporosis?	1	2	3