



Female Health History Questionnaire

(To be completed by patient)

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Name: _____ Date: _____

Address _____ City _____ State ____ Zip Code _____

Home Phone (____) _____ Cell (____) _____ Email _____

Age ____ Date of Birth ____/____/____ Gender: ____ Female ____ Male

Referred by: _____

Name, address, & phone number of primary care physician: _____

Marital Status:

____ Single ____ Married ____ Divorced ____ Widowed ____ Long Term Partnership

Occupation _____ Hours per week ____ Retired _____

Nature of Business _____

Genetic Background: Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

CURRENT HEALTH STATUS/CONCERNS



Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

When was the last time that you felt well? _____

What seems to trigger your symptoms? _____

What seems to worsen your symptoms? _____

What seems to make you feel better? _____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions? _____

How much time have you lost from work or school in the past year due to these conditions? _____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		
ILLNESS	WHEN/ONSET	COMMENTS
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		

Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
INJURIES	WHEN	COMMENTS
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	WHEN	COMMENTS
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		

Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications you are currently on. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?

Yes ___ No ___

If yes, please list: _____

CHILDHOOD HISTORY

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms?
Yes___ No___

If yes, please explain: (Example: milk – diarrhea)_____

CHILDHOOD ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	YES	AGE		YES	AGE
ADD (Attention Deficient Disorder)			Mumps		
Asthma			Pneumonia		
Bronchitis			Seasonal allergies		
Chicken Pox			Skin disorders (e.g. dermatitis)		
Colic			Strep infections		
Congenital problems			Tonsillitis		
Ear infections			Upset stomach, digestive problems		
Fever blisters			Whooping cough		
Frequent colds or flu			Other (describe)		
Frequent headaches			Other (describe)		
Hyperactivity			Measles		
Jaundice					

As a child did you: Have a high absence from school? Yes___ No___

If yes, why?_____

Experience chronic exposure to second hand smoke in your home? Yes___ No___

Experience abuse Yes___ No___ Have alcoholic parents? Yes___ No___



FEMALE MEDICAL HISTORY

(For women only)

Female Anatomy / Reproductive Health (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

DIAGNOSTIC TESTING

Last PAP test: ___/___/___ Normal: _____ Abnormal _____

Last Mammogram: ___/___/___ Breast biopsy? Date: ___/___/___

Date of last bone density: ___/___/___ Results: High___ Low___ Within normal range___



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: _____

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? _____

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

Do you experience any unusual or excessive vaginal discharge throughout the month?

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? _____

Menopausal Women

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

Date of your last menstrual period? _____

Please describe any recent changes and/or symptoms associated with your cycle prior to menopause: _____

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: _____

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Substance abuse (such as alcoholism)									
Ulcers									

REVIEW OF SYMPTOMS

Check (✓) those items that applied to you in the **past**. **Circle** those that **presently** apply.

GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Sleepwalker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted vision

SKIN:

- Cuts heal slowly
- Bruise easily
- Rashes
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness/cracking skin
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Bumps on back of arms & front of thighs
- Skin cancer
- Strong body odor
- Is your skin sensitive to:**
 - Sun
 - Fabrics
 - Detergents
 - Lotions/Creams

HEAD:

- Poor Concentration
- Confusion
- Headaches:
 - After Meals
 - Severe
 - Migraine
 - Frontal
 - Afternoon
 - Occipital
 - Afternoon
 - Daytime
 - Relieved by:
 - Eating Sweets
- Concussion/Whiplash
- Mental sluggishness
- Forgetfulness
- Indecisive
- Face twitch
- Poor memory
- Hair loss

EYES:

- Feeling of sand in eyes
- Double vision
- Blurred vision
- Poor night vision
- See bright flashes
- Halo around lights
- Eye pains
- Dark circles under eyes
- Strong light irritates
- Cataracts
- Floaters in eyes
- Visual hallucinations

EARS:

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing hallucinations

NOSE/SINUSES

- Stuffy
- Bleeding
- Running/Discharge
- Watery nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

- Spring
- Summer
- Fall
- Winter

MOUTH:

- Coated tongue
- Sore tongue
- Teeth problems
- Bleeding gums
- Canker sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

THROAT:

- Mucus
- Difficulty swallowing
- Frequent hoarseness
- Tonsillitis
- Enlarged glands
- Constant clearing of throat
- Throat closes up

NECK:

- Stiffness
- Swelling
- Lumps
- Neck glands swell

CIRCULATION/RESPIRATION:

- Swollen ankles
- Sensitive to hot
- Sensitive to cold
- Extremities cold or clammy
- Hands/Feet go to sleep/numbness/tingling
- High blood pressure
- Chest pain
- Pain between shoulders
- Dizziness upon standing
- Fainting spells
- High cholesterol
- High triglycerides
- Wheezing
- Irregular heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently sighing
- Shortness of breath
- Night sweats
- Varicose veins/spider veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Prior heart attack ? When ___/___/___
- Phlebitis

GASTROINTESTINAL

- Peptic/Duodenal Ulcer
- Poor appetite
- Excessive appetite
- Gallstones
- Gallbladder pain
- Nervous stomach
- Full feeling after small meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea
- Constipation
- Changes in bowels
- Rectal bleeding
- Tarry stools
- Rectal itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

KIDNEY/URINARY TRACT:

- Burning
- Frequent urination
- Blood in urine
- Night time urination
- Problem passing urine
- Kidney pain
- Kidney stones
- Painful urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

WOMEN'S HISTORY (for women only)

- Fibrocystic breasts
- Lumps in breast
- Fibroid Tumors/Breast
- Spotting
- Heavy periods
- Fibroid Tumors/Uterus

WOMEN'S HISTORY (for women only)

- Painful periods
- Change in period
- Breast soreness before period
- Endometriosis
- Non-period bleeding
- Breast soreness during period
- Vaginal dryness
- Vaginal discharge
- Partial/total hysterectomy
- Hot flashes
- Mood swings
- Concentration/Memory Problems
- Breast cancer
- Ovarian cysts
- Pregnant
- Infertility
- Decreased libido
- Heavy bleeding
- Joint pains
- Headaches
- Weight gain
- Loss of bladder control
- Palpitations

MEN'S HISTORY (for men only)

Have you had a PSA done?

Yes _____ No _____

PSA Level:

- 0 – 2
- 2 – 4
- 4 – 10
- >10

- Prostate enlargement
- Prostate infection
- Change in libido
- Impotence
- Diminished/poor libido
- Infertility
- Lumps in testicles
- Sore on penis
- Genital pain
- Hernia
- Prostate cancer
- Low sperm count
- Difficulty obtaining erection
- Difficulty maintaining an erection
- Nocturia (urination at night)
 - How many times at night? _____
- Urgency/Hesitancy/Change in Urinary Stream
- Loss of bladder control

JOINT/MUSCLES/TENDONS

- Pain wakes you
- Weakness in legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle stiffness in morning
- Damp weather bothers you

EMOTIONAL:

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts/Amnesia
- Had prior shock therapy
- Frequently keyed up and jittery
- Startled by sudden noises
- Anxiety/Feeling of panic
- Go to pieces easily
- Forgetful
- Listless/groggy
- Withdrawn feeling/Feeling 'lost'
- Had nervous breakdown
- Unable to concentrate/short attention span
- Vision changes
- Unable to reason
- Considered a nervous person by others
- Tends to worry needlessly
- Unusual tension

EMOTIONAL (CONTINUED)

- Frustration
- Emotional numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Previously admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Misunderstood by others
- Irritable/
- Feeling of hostility/volatile or aggressive
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

PAIN ASSESSMENT

Are you currently in pain? Yes ___ No ___

Is the source of your pain due to an injury? Yes ___ No ___

If yes, please describe your injury and the date in which it occurred: _____

If no, please describe how long you have experienced this pain and what you believe it is attributed to: _____

Please use the area(s) below to describe the severity of your pain and place the corresponding letter that best characterizes the pain.

(1= no pain, 10= severe pain)

(A = ache, B= burning, N=numbness, S= stiffness, T=tingling, Z=sharp/shooting)

Example: Neck - T

1 2 3 4 5 **6** 7 8 9 10

Area 1. _____
1 2 3 4 5 6 7 8 9 10

Area 2. _____
1 2 3 4 5 6 7 8 9 10

Area 3. _____
1 2 3 4 5 6 7 8 9 10

Area 4. _____
1 2 3 4 5 6 7 8 9 10

Area 5. _____
1 2 3 4 5 6 7 8 9 10

Area 6. _____
1 2 3 4 5 6 7 8 9 10

DENTAL HISTORY

	<u>Yes</u>	<u>No</u>
Problem with sore gums (gingivitis)?	_____	_____
Ringing in the ears (tinnitus)?	_____	_____
Have TMJ (temporal mandibular joint) problems?	_____	_____
Metallic taste in mouth?	_____	_____
Problems with bad breath (halitosis) or white tongue (thrush)?	_____	_____
Previously or currently wear braces?	_____	_____
Problems chewing?	_____	_____
Floss regularly?	_____	_____
Do you have amalgam dental fillings? How many?	_____	_____
Did you receive these fillings as a child?	_____	_____

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes____ No____

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? Yes____ No____

- | | |
|--|--|
| <input type="checkbox"/> Ovo-lacto | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Dairy restricted | <input type="checkbox"/> Blood type diet |
| <input type="checkbox"/> Other (describe)_____ | |

Please tell us if there is anything special about your diet that we should know. _____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc? Yes____ No____

If yes, are these symptoms associated with any particular food or supplement? Yes____ No____

If yes, please name the food or supplement and symptom(s). _____

Do you feel that you have delayed symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)

Yes____ No____

Do you feel **worse** when you eat a lot of:

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | <input type="checkbox"/> Other_____ |

Do you feel **better** when you eat a lot of:

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | <input type="checkbox"/> Other _____ |

Does skipping meals greatly affect your symptoms? Yes ____ No ____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes ____ No ____ If yes, what food(s) _____

Do you have an aversion to certain foods? Yes ____ No ____

If yes, what food(s) _____

Please complete the following chart as it relates to your bowel movements:

Frequency	√	Color	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose			

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ___ No ___

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___ How much? ___

Number of years? _____ If not a current user, year quit _____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain: _____

ALCOHOL INTAKE

Have you ever used alcohol? Yes ___ No ___

If yes, how often do you now drink alcohol?

- No longer drink alcohol
- Average 1-3 drinks per week
- Average 4-6 drinks per week
- Average 7-10 drinks per week
- Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes ___ No ___

Have you ever had a problem with alcohol? Yes ___ No ___

If yes, indicate time period (month/year) From _____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes ___ No ___

If yes, what type(s) and method? (IV, inhaled, smoked, etc) _____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes ___ No ___

If yes, indicate which

- Lead
- Arsenic
- Aluminum
- Cadmium
- Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10___ 8-10___ 6-8___ less than 6___

Do you:

- | | |
|---|--|
| <input type="checkbox"/> Have trouble falling asleep? | <input type="checkbox"/> Use sleeping aid? |
| <input type="checkbox"/> Feel rested upon waking? | |
| <input type="checkbox"/> Have problems with insomnia? | <input type="checkbox"/> Snore? |

EXERCISE HISTORY

Do you exercise regularly? Yes ___ No ___

If yes, please indicate:

Type of exercise	Times/week				Length of session			
	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45 min
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (low motivation, fatigue after exercising, etc)

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes ___ No ___

Do you feel you can easily handle the stress in your life? Yes ___ No ___

If no, do you believe that stress is presently reducing the quality of your life? Yes ___ No ___

If yes, do you believe that you know the source of your stress? Yes ___ No ___

If yes, what do you believe it to be? _____

Have you ever contemplated suicide? Yes ___ No ___

If yes, how often? ___ When was the last time? ___



Have you ever sought help through counseling? Yes ___ No ___

If yes, what type? (e.g., pastor, psychologist, etc) _____

Did it help? _____

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

Spouse Family Friends Religious/Spiritual Pets Other _____

Have you ever been involved in abusive relationships in your life? Yes ___ No ___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes ___ No ___

Did you feel safe growing up? Yes ___ No ___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No ___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No ___

How important is religion (or spirituality) for you and your family's life?

a. ___ not at all important b. ___ somewhat important c. ___ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? _____

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other _____

Hobbies and leisure activities:

Is there anything that you would like to discuss with the doctor today that you feel was not covered on this form? Yes_____ No_____

Comments _____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Take nutritional supplements each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Keep a record of everything you eat each day	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Modify your lifestyle (e.g. work demands, sleep habits)	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Practice relaxation techniques	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Engage in regular exercise	5 _____ 4 _____ 3 _____ 2 _____ 1 _____
Have periodic lab tests to assess progress	5 _____ 4 _____ 3 _____ 2 _____ 1 _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and wellbeing.

Yours in Health,

Dr. Doris Kutz-Compton & Staff

This questionnaire is an adaptation of the Comprehensive Health History created by Wayne L. Sodano, D.C., D.A.B.C.I. and Ron Gristanti, D.C., D.A.B.C.O., M.S. at the Functional Medicine University. Sequoia Education Systems, Inc.