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# Confidential Medical History – Female

Date: _____

Name: _____ Date of Birth: _____ Age:_____

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email:_____

## Please list all medical providers that you currently see

| Provider's Name | Specialty | Address | Phone |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |

## Social History:

| | | | If yes, how often, how much |
|---|---|---|---|
| Do you use tobacco? | _____ Yes | _____ No | _____ |
| Do you use alcohol? | _____ Yes | _____ No | _____ |
| Do you use caffeine? | _____ Yes | _____ No | _____ |

## Medical Conditions/Disease – Please check any and all that apply to you

____ Heart disease (ex. congestive heart failure)
____ High cholesterol or lipids (ex. Hyperlipidemia)
____ High blood pressure
____ Cancer _____
____ Ulcers (stomach, esophagus)
____ Thyroid disease _____
____ Hormonal related problems
____ Blood clotting problems
____ Lung condition (ex. asthma, emphysema, COPD)
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye disease (glaucoma, etc)
____ Other: Please list

_____
_____
_____

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**Menstrual History:**

Age at first period _____ Date of last menstrual period _____

Length of cycle _____ Time between cycles_____
Have you ever had Premenstrual Syndrome (PMS)? _____ Yes _____ No
If yes, please describe symptoms: _____

Do you have other problems with your periods (heavy, irregular, spotting, etc.)? ___Yes ___No
If yes, please describe:_____

Are you currently on a hormonal birth control or have you been on hormonal birth control in the past (birth control pills, patch, Nuva ring)? _____ Yes _____No
If yes, explain _____

Any problems with hormonal birth control? _____ Yes _____No
If yes, explain _____

Use of other contraception (condoms, diagphragm, IUD, partner vasectomy)? ___ Yes ___ No
If yes, what type? _____

Are you on hormone replacement therapy? _____Yes _____ No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?
_____

| List any hormones that you have previously taken | Date Started | Date Stopped | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Please list any surgeries you have had:**

_____
_____
_____
_____

**Primary reason you came for evaluation:** _____
_____
_____

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**Allergies:** Please check any and all that apply

| | | | |
|---|---|---|---|
| ____ Penicillin | ____ Morphine | ____ Dye allergies | ____ Pet allergies |
| ____ Codeine | ____ Aspirin | ____ Nitrate allergies | ____ Seasonal (pollen) |
| ____ Sulfa drugs | ____ Food allergies | ____ Other | ____ No known allergies |

Please describe the allergic reaction to the above allergens:

**Current Medications:**

| Medication | Dose | Frequency | Reason Why |
|---|---|---|---|
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**Supplements & Vitamins**

| Name | Dose | Frequency | Reason Why |
|---|---|---|---|
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Please check all of the over-the-counter products that you occasionally or regularly use.

| Occasional Use | Regular Use | | Occasional Use | Regular Use | |
|---|---|---|---|---|---|
| | | Pain Reliever | | | Combination product, cough + cold reliever (ex: Triaminic®) |
| | | Aspirin | | | Sleep aids (ex. Excedrin PM®, Unisom®, Sominex®) |
| | | Acetaminophen (ex. Tylenol®) | | | Antidiarrheals (ex. Imodium®, Pepto Bismal®, aopectate®) |
| | | Ibuprofen (ex. Motrin IB®) | | | Laxatives/stool softeners (ex. Doxidan®, Correctol®) |
| | | Naproxen (ex. Aleve®) | | | Diet aids/weight loss products (ex. Desatrim®) |
| | | Ketoprofen (ex. Orudis KT®) | | | Antacids (ex. Maalox®, Mylanta®) |
| | | Cough suppressant (ex. Robitussin DM®) | | | Acid blockers (ex. Tagamet HB®, Pepcid AC®, Zantac 75®) |
| | | Antihistamine (ex. Chlor-Trimeton®) | | | Other (please list) |
| | | Decongestant (ex. Sudafed®) | | | |

**Antibiotic History:** Have you ever taken repeated courses of antibiotics as a child for ear, throat, or respiratory infections, as a teen for acne, or as an adult for any significant infections? If so, offer brief detail. _____

_____

**Do you have a family history of any of the following?**

| | | Family member(s) |
|---|---|---|
| Heart Disease | ____ | _____ |
| Osteoporosis | ____ | _____ |
| Diabetes | ____ | _____ |
| HTN | ____ | _____ |
| Stroke | ____ | _____ |
| Depression | ____ | _____ |
| Anxiety | ____ | _____ |
| Dementia | ____ | _____ |
| Breast Cancer | ____ | _____ |
| Uterine Cancer | ____ | _____ |
| Ovarian Cancer | ____ | _____ |

**Have you had any of the following tests performed?**

| | | | | | | |
|---|---|---|---|---|---|---|
| Mammogram or Thermography | ____ | No | ____ | Yes | Date: | _____ |
| Pap smear | ____ | No | ____ | Yes | Date: | _____ |
| General dental cleaning | ____ | No | ____ | Yes | Date: | _____ |
| Colonoscopy | ____ | No | ____ | Yes | Date: | _____ |
| Eye exam by Optometrist or Ophthalmologist | ____ | No | ____ | Yes | Date: | _____ |
| Full skin exam by Dermatologist | ____ | No | ____ | Yes | Date: | _____ |
| EKG | ____ | No | ____ | Yes | Date: | _____ |
| Cardiac Stress Test | ____ | No | ____ | Yes | Date: | _____ |
| Chest X-ray | ____ | No | ____ | Yes | Date: | _____ |

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**Nutritional Assessment:**

Any history of food sensitivities or allergies?

_____

Do you experience signs or symptoms of low blood sugar? (drop in energy, fuzzy headed, shaky, need frequent meals)

_____

If one serving of vegetables is represented as ½ cup of cooked vegetables or 1 cup of raw vegetables, how many servings of vegetables do you eat daily on average?

_____

How many servings of fish do you eat in a week on average? Name the two most common types of fish that you eat.

_____

How many servings of fruit do you eat daily?

_____

How much water do you drink on a daily basis?

_____

How often do you eat out at restaurants?

_____

**Please list your typical day's food and beverage intake?** List food and beverage serving size.

**Breakfast:** _____

_____

_____

**Lunch:** _____

_____

_____

**Dinner:** _____

_____

_____

**Snacks:** _____

_____

_____

**Soft drink consumption, type and amount:** _____

_____

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**Exercise:** Do you exercise regularly? If so, what type of exercise? How often? If you do not exercise, briefly state what is limiting you from doing so.

_____

_____

**Sleep:**

How many hours of sleep do you get each night on average? _____
Do you have problems falling asleep? _____
Do you have problems staying asleep? _____
Do you snore? _____
Do you share a bed with another person or pet? _____
Does your partner/significant other snore? _____
Do you feel rested upon awakening? _____
Do you use sleeping aids? If yes, what kind? _____

Do you consider yourself to be under much stress (please explain)?

_____

_____

_____

Please select all the methods you use to relieve tension and/or stress

| | | |
|---|---|---|
| _____ Read | _____ Meditate | _____ Do nothing |
| _____ Listen to music/play music | _____ Blow up | _____ Turn to faith/pray |
| _____ Smoke cigarettes/pipe | _____ Eat | _____ Take a mind altering drug |
| _____ Sleep | _____ Exercise or walk | _____ Go for a drive |
| _____ Watch television | _____ Don't think about it | _____ Call a friend/relative |
| _____ Cry | _____ Work/housework | _____ Draw/paint |
| _____ Throw things | _____ Have an alcoholic drink | _____ Enjoy a hobby |

**Environmental Toxin Exposure:**

What type of laundry detergent and dryer sheets do you use? _____
Do you use air freshener, scented candles or other scented products at home or at work? ____
Do you use scented hand sanitizer, lotions or perfumes/colognes? _____
Do you wear outdoor shoes in your home? _____
Are you exposed to herbicides, pesticides, or fungicides ie. golf courses, outdoor parks or in your home ?

_____

Are you familiar with the "Dirty Dozen & Clean 15" food guidelines? _____
Do you store or heat food in plastic containers? _____

**Signature:** _____

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How did you hear about us? _____

## Symptom review

**Score** 0 = Never 1 = Mild 2 = Moderate 3 = Moderately Severe 4 = Severe

| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| **Endocrine** | | | | | |
| Cold hands and feet | | | | | |
| Cold intolerance | | | | | |
| Daytime sleepiness | | | | | |
| Early waking | | | | | |
| Fatigue | | | | | |
| Heat intolerance | | | | | |
| Heavy menstrual bleeding / breakthrough bleeding | | | | | |
| Vaginal dryness | | | | | |
| Breast swelling / tenderness | | | | | |
| Hot flashes | | | | | |
| Night sweats | | | | | |
| Decreased sex drive | | | | | |
| Harder to reach climax | | | | | |
| Poor response to add / or Recovery from exercise | | | | | |
| Excessive stress in my life on a daily basis | | | | | |
| Strong cravings for sugar or carbohydrates | | | | | |
| Experience increased thirst | | | | | |
| | | | | | |
| **Musculoskeletal** | | | | | |
| Joint pain | | | | | |
| Joint stiffness | | | | | |
| Muscle pain | | | | | |
| Muscle spasm | | | | | |
| Muscle stiffness | | | | | |
| Muscle weakness | | | | | |
| Neck pain | | | | | |
| | | | | | |
| **Mood** | | | | | |
| Anxiety | | | | | |
| Depression | | | | | |
| Dizziness/vertigo | | | | | |
| Fainting | | | | | |
| Irritability | | | | | |
| Panic attack | | | | | |

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|---|---|---|---|---|---|
| | | | | | |
| **Cardiovascular** | | | | | |
| Breathlessness | | | | | |
| High blood pressure | | | | | |
| Elevated cholesterol | | | | | |
| Irregular pulse | | | | | |
| Palpitations | | | | | |
| Swollen ankles/feet | | | | | |
| Varicose veins | | | | | |
| Loss of hair on the lower leg | | | | | |
| | | | | | |
| **Gastrointestinal** | | | | | |
| Gas, bloating, or general discomfort after eating | | | | | |
| Heartburn / acid reflux | | | | | |
| Constipation | | | | | |
| Diarrhea | | | | | |
| Nausea | | | | | |
| Recurrent vaginal yeast | | | | | |
| History of IBS, Crohn's or Ulcerative colitis | | | | | |
| Mucous in stool | | | | | |
| Stool appears black or looks like tar | | | | | |
| Undigested food in stool | | | | | |
| Upper abdominal pain | | | | | |
| Vomiting | | | | | |
| White coating or plaque on tongue | | | | | |
| | | | | | |
| **Neurological** | | | | | |
| Loss of feeling in hands or feet | | | | | |
| Tingling sensation or lack of feeling in extremities | | | | | |
| Lightheadedness or fainting | | | | | |
| Weakness to one or more extremities | | | | | |
| Loss of balance, dizziness, or vertigo | | | | | |
| Poor cognition or poor memory | | | | | |
| Poor mental focus or concentration | | | | | |
| Frequent headaches | | | | | |
| | | | | | |
| **Respiratory** | | | | | |
| Cough | | | | | |
| Hayfever | | | | | |
| Hoarseness | | | | | |
| Nasal stuffiness | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Post nasal drip | | | | | |
| Sinus fullness | | | | | |
| Sinus infections | | | | | |
| Snoring | | | | | |
| Sore throat | | | | | |
| Wheezing | | | | | |
| | | | | | |
| **Skin** | | | | | |
| Acne | | | | | |
| Athlete's foot | | | | | |
| Dryness | | | | | |
| Easy bruising | | | | | |
| Eczema | | | | | |
| Herpes - genital | | | | | |
| Hives | | | | | |
| Oily skin | | | | | |
| Psoriasis | | | | | |
| Rash | | | | | |
| History of shingles | | | | | |