FEMALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

_____

_____

2. List medications you are currently taking:

_____

_____

3. Any known drug allergies? _____

4. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

_____

_____

_____

5. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

_____

_____

_____

6. Date of last pelvic/gynecological exam: _____ Last Pap Test: _____ Last mammogram: _____
7. Last thermography? _____ Unusual results? _____
8. List significant non-GYN health issues (diabetes, surgeries, etc.):

_____

_____

LIFESTYLE INDICATORS **< = less than > = greater than**

1. Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day
Coffee	None	<2 cups/day	>2 cups/day
Soda	None	<2 cans/day	>2 cans/day
Sweets/refined carbs		<twice/day	>twice/day

2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No How much/often? _____
3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10
5. How often do you exercise? never rarely sometimes regularly competitively

INSTRUCTIONS: Check either "Ongoing" or "Just w/ Period" for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity.

SIGNS & SYMPTOMS	ONGOING	JUST W/ PERIOD	MILD	MODERATE	SEVERE	MORE INFORMATION
Mood swings						
Anxiety/Nervousness						
Overly Reactive/Short fuse						
Irritability						
Depression						
Lowered self-esteem/self-image						
Caretake others before yourself						
Sadness/Crying						
Foggy thinking						
Memory difficulties						
Fatigue						
Constant hunger						
Sweet cravings (carbs/chocolate)						
Caffeine/Stimulant cravings						
Salt cravings						
Headaches/Migraines						
Body/Joint Aches/Backache						
Weight gain						
Weight loss						
Water Retention						
Bloating						
Irritable Bowel						
Constipation						
Light colored stool						
Loose stool/Diarrhea						
Nausea/vomiting						
Acne						
Excessive facial hair						
Body/Head hair loss						
Dry skin/Brown spots						
Lowered libido						
Heightened libido						
Hot flashes						
Night sweats						
Breast tenderness/swelling						
Nipple discharge						
Vaginal infections						
Urinary frequency						
Incontinence						
Vaginal dryness						
Painful intercourse						

Any other symptoms? _____

_____

REPRODUCTIVE HEALTH HISTORY *(please fill in or circle the appropriate answer)*

1. Age at onset of menarche (first period): _____ Approximate date of onset: _____
2. Are you currently using a method of birth control? Yes No
   If yes, what method? _____
3. Are you, or have you used *(please circle)* oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception (aka "the day after" pill)? Yes No
   When and for how long? _____
4. Are you, or have you used an IUD? Yes No If yes, when and for how long? _____
   What type of IUD did you use? copper hormone other _____
5. Please describe problems that you may have experienced associated with the use of any and all birth control methods *(such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)*

   _____

   _____

   _____
6. Have you used, or are you currently using fertility or treatment? Yes No
   If yes, please explain. _____
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, what hormone(s), dosage, & for how long? _____

   _____

8. Have you been pregnant before? Yes No Age(s) of children: _____

Number of pregnancies? _____ Details/ Complications: _____

Number of live births: _____ _____

Miscarriages: _____ _____

Premature births: _____ _____

Cesarean births: _____ _____

Stillbirths: _____ _____

Abortions: _____ _____

Ectopic pregnancies _____ _____

9. If you have had a miscarriage, how many weeks pregnant were you? _____
10. Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: _____
    Treatment and/or Medication: _____
11. Have you had a vaginal infection? Yes No If yes, what? _____
    Treatment and/or Medication: _____
12. Any history of… Ovarian cysts? Yes No Uterine fibroids? Yes No
    Fibrocystic Breasts? Yes No Endometriosis? Yes No
    Polycystic Ovarian Syndrome (PCOS)? Yes No

FOR CYCLING-AGE WOMEN *(please fill in or circle the appropriate answer)*

1. First day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes No When? _____
2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No
   If yes, please give details. _____
   _____
   _____
   _____
3. How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)
   <20 _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
4. How many days does menstruation typically last? _____
5. Is your cycle regular? Yes No Not Always Details: _____
6. Typical menstrual flow: Light Medium Heavy Details: _____
7. How many *pads* and/or *tampons* (circle) are used on heavy days? _____
8. Do you pass clots? Yes No How often? _____
9. Do you spot? Yes No At what point in your cycle?_____
10. Do you experience cramping? None Mild Moderate Severe
    At what point in your cycle? _____
11. Do you experience abnormal vaginal discharge? Yes No If yes, when? _____
12. Do you experience vaginal itching and/or odor? Yes No If yes, when? _____
13. Do you experience breast tenderness? None Mild Moderate Severe
    At what point in your cycle? _____ Change in breast size? Yes No
14. Do experience nipple discharge? Yes No If yes, when? _____ Color?_____

FOR MENOPAUSAL WOMEN *(please fill in or circle the appropriate answer)*

1. Your age at the onset of menopause: _____ Year of onset: _____
2. Have you had a hysterectomy? complete *(ovaries AND uterus)* partial *(uterus only)*
3. Date of hysterectomy: _____ Reason for hysterectomy: _____
   _____
   _____
4. List any other GYN related surgeries: _____
   _____
5. Describe your experience transitioning into menopause *(symptoms, strong emotions, thoughts, unusual stressors, etc.)*
   _____
   _____
   _____
   _____

MENOPAUSAL WOMEN, CONT'D

6. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes No

   If yes, what were you prescribed? _____

   What dosage? _____ For how long? _____

7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Yes No

   If yes, what? _____

   What dosage? _____ For how long? _____

8. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No

   If yes, what? _____

   For how long? _____

9. Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No

   If yes, when? _____ Were you evaluate and/or treated by a GYN? Yes No

   Treatment: _____

PLEASE DESCRIBE YOUR CYCLE HISTORY.

10. How would you have described your menstruation?

    Easy Uncomfortable Difficult Debilitating

11. What was your typical menstrual flow? Light Medium Heavy

12. When you were cycling would you consider your cycle regular? Yes No

    If no, explain. _____

Please describe any 'treatment' ever received for cycle issues. _____

_____

_____

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

   How long has this been happening? _____

2. How many hours do you sleep a night on average? _____

3. Do night sweats wake you up? Yes No How often? _____

4. Do you wake up tired? Yes No How long has this been happening? _____

5. Is your room completely dark when you sleep at night? *(no night light, street lamp, TV, etc.)* Yes No

6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

Middletown 717-944-2225
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Dietary/Response Log Instructions: So that your diet can be accurately evaluated, please write down everything you eat for 4 days. It is important to write down everything, including snacks, candy, coffee, all beverages, amount of water, and additives (sugar, salt, Splenda, Nutri-Sweet, etc). Include the approximate amounts of the food, such as 2 tbsp. peas; 1 large hamburger; small glass of orange juice. If the information is not typical of your normal diet—for example, if you are not feeling well and you appetite is poor– include this in the last section of each column. Please also record how you are feeling that day and changes or improvements you have noticed. This may include physical, mental or emotional symptoms.

1st Day Date _____	2nd Day Date _____	3rd Day Date _____	4th Day Date _____
Breakfast	Breakfast	Breakfast	Breakfast
Snack	Snack	Snack	Snack
Lunch	Lunch	Lunch	Lunch
Snack	Snack	Snack	Snack
Dinner	Dinner	Dinner	Dinner
Snack	Snack	Snack	Snack
How are you feeling?	How are you feeling?	How are you feeling?	How are you feeling?

Patient Name _____ Date _____

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WELLNESS HISTORY QUESTIONNAIRE

Date: _____

Name: _____ DOB: _____ Age:_____

Weight: _____ Height: _____ Tel #: (H)_____(Wk)_____

Current Occupation: _____ Marital Status: Single Married Divorced Separated Widow

Primary Care Physician/Family Doctor: _____

List any medication with dosages (prescription/non-prescription) that you are currently taking: _____
_____
_____

Do you feel the medication is helping you? _____

List any nutritional supplements (vitamins, minerals, herbal products, etc.) you are currently taking: _____
_____
_____

Do you feel the nutritional supplements are helping you? For example, do you notice a specific improvement in the way you feel? _____

Please check any condition which you currently have or have had in the past:
___ AIDS ___ Arthritis ___ Asthma ___ High blood pressure ___ Low blood pressure ___Heart attack ___ Stroke
___ Hardening of the arteries ___Chronic Fatigue Syndrome ___ Depression ___ Diabetes ___ Eating disorder
___ Fibromyalgia ___ Hypothyroidism ___ Hyperthyroidism ___ Sinusitis ___ Chronic Pain/Numbness
___ Gallbladder Problems ___ High Cholesterol ___ Insomnia ___ Low Back Pain ___ Neck Pain ___Acid Reflux
___ Migraines ___ Cancer ___ Epilepsy ___ Parkinson's Disease ___ Multiple Sclerosis___Gout
___ Irritable Bowel Syndrome ___ Crohn's Disease/Ulcerative Colitis

Do you have any children? Y N If yes, do you children have any major medical problems? (Past or present)? Y N If yes, please describe_____
_____

Do you have any siblings? Y N If yes, please list any major medical problems that are part of your siblings' history _____

Are your parents still living? Y N Are there any major medical problems (past or present) that are part of your parents' history? _____
_____

Do your maternal or paternal grandparents have any major medical problems (past or present) that are part of their history? Y N If yes, please describe_____
_____

Please list any previous surgeries, accidents, injuries, fractures, or hospitalizations: _____
_____

Please list any other health care providers you are currently seeing and for what condition: _____
_____
_____

DIET:

List a typical day's food intake: _____
_____
_____
_____

What are foods you crave? _____
_____

What foods do you especially like? _____
_____

How often do you eat them? _____

What foods do you avoid? _____
_____

Do any foods seem to irritate you in some way? _____
_____

Beverages: please list how many drinks per week:
Coffee _____ Tea _____ Beer _____ Wine _____ Other Alcohol _____ Soda _____ Water _____
Carbonated or Sparkling Water _____

Check all that apply:

____ Do you add sugar or sugar substitutes to food or drinks?
____ Do you eat foods with added sugar?
____ Do you add salt to food?
____ Do you crave salt?
____ Do you eat fried foods more than twice per week?
____ Do you eat fast food (McDonald's, Burger King, etc.) more than once per week?
____ Do you eat processed or convenience foods (Hamburger Helpers, TV dinners, Frozen Pot Pies, etc.) more than twice per week?
____ Do you often eat foods containing preservatives and color or flavoring additives?
____ Do you eat chocolate or sweets more than twice per week?
____ Does less than a third of your diet consist of raw fruit and vegetables?
____ Do you eat foods containing white flour, white rice, and white bread?
____ Do you eat whole grains such as brown rice, whole oats, beans, or millet?
____ Do you drink milk?
____ Do you eat more than three slices of bread per day?
____ Are there foods you feel addicted to?
____ Use low calorie diets to lose weight
____ Eat less than 2,000 calories per day
____ Skip meals, especially breakfast
____ Eat mainly cereal for breakfast
____ Eat mostly low-fat foods
____ Think about weight several times a day
____ Crave sweets or alcohol
____ Do you feel drowsy after meals?

____ Do you feel hungry, no matter how much you eat?
____ Do you feel better after eating?
____ Do you feel worse after eating?
____ Do you watch what you eat to avoid gaining weight?
____ Do you watch what you eat to avoid losing weight?
____ Do you snack frequently between meals? If yes, please list favorite snacks: _____
_____
____ Do you prefer butter over margarine?
____ Do you know of any foods you may be allergic to? If yes, please list: _____
_____
____ Do you prefer beverages to solid food?
____ Do you use a lot of condiments?
____ Do you avoid or cut fat from your meat?
____ Do you eat organic produce?

PHYSICAL:
____ Frequent thirst
____ Feel stressed, overwhelmed, or exhausted
____ Easily chilled
____ Gain weight without overeating, hard to lose
____ Chronic Headaches
____ Urination: Frequent/Infrequent (please circle); color: _____
____ Diarrhea
____ Constipation
____ Excessive sweating
____ Swelling in Hands/Feet
____ Near-sightedness
____ Far-sightedness

IMMUNE:
____ Yeast infections
____ Take antibiotics more than twice per year
____ Ear infections as a child or adult
____ Allergies
____ Frequent colds
____ Does it take more than 1 week to overcome an infection?

STRESS:
____ Obsessive thinking or behavior
____ Do you feel guilty when relaxing?
____ Are you unclear about goals?
____ Have you had an extraordinary experience (marriage, children, death of family member/friend, job change, accident, relationship change) in the last 18 months?
____ Do you work harder than most people?
____ Do you often do multiple tasks at one time?
____ Low self-esteem
____ Often irritable
____ Use alcohol, drugs, herbs, caffeine, or other stimulants to improve mood
____ Do you enjoy your job? Do you feel it is an expression of your interests?
____ Do you practice any stress reduction techniques (exercise, meditation, yoga, etc.)?
____ Do you believe that your actions can affect your health?

LIFESTYLE:
____ Do you cry easily?
____ Do you eat as a reward to comfort or to numb?
____ Do you worry, have phobia, or panic?

____ Do you have difficulty getting to sleep or staying asleep?
____ Are you wide awake within 20 minutes of rising?
____ Do you need something to get you going in the morning such as caffeine or nicotine?
____ Do you have difficulty focusing?
____ Low energy, drive, or arousal
____ Do you have time to socialize or pursue personal interests?
____ Do you regularly take time for yourself?
____ Do you have at least one person in whom you can confide?
____ Do you participate in exercise that noticeably raises your heartbeat for at least 20 minutes, three times per week?
Please list any exercise that you do regularly: _____
_____
____ Do you have activities in your life or job that involve walking, lifting, or movement (playing with children, gardening, woodworking, cleaning)
____ Do you consider yourself fit?

What do you hope to receive from Nutritional Counseling?_____
_____
_____
_____

Reviewed by: _____
Provider