

## Patient Information

(Please Print)

Information			
Last name:	First:	Middle	Birth Date:
			Age:
Social Security No			
Marital Status (circle one)	Gender	Known Drug Allergies:	
Single/Married/Divorced/Widowed	M or F		
Street Address:			Apt/Unit #
			P O Box ( if applicable)
City			State
			Zip Code
Home Phone		Work Phone:	
		Cell Phone:	
e-mail 1:		e-mail 2:	
Circle Preferred Phone #:		Circle Preferred e-mail:	
Home	Work	Cell	e-mail 1
		e-mail 2	
Occupation		Employer	
Physician/Gynecologist		Physician/Gynecologist Phone #	
Referred By:			
In Case of Emergency			
Name:	Relationship	Home Phone #	Work/Cell Phone #
Name:	Relationship	Home Phone #	Work/Cell Phone #
Consents			
<b>Initial</b>	By initialing here, I understand that I am financially responsible for all charges whether or not the charges are covered by insurance.		

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**All the information provided above is complete and accurate to the best of my knowledge.**

## Medical History Information

(Please Print)

\_\_\_\_\_  
Name

**Current Ailments:**

Below, describe all of your complaints/symptoms in order of severity, list how long you have had them and how you are treating the complaints/symptoms. Be sure to mention any drugs, nutritional supplements, or other medical substances you are taking:

	Complaints/Symptoms	How long?	Treatment
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

What is your chief complaint? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any **prescribed and over the counter** medications you are **currently taking**:

	Medication	Strength: units in mg, gm, IU, mcg	Frequency	Year Started	Reason
1					
2					
3					
4					
5					
6					
7					

\*\* Please use back of sheet if needed, and indicate that there is more medication information on back of sheet.

List any **Hormones** previously taken (including birth control, female or male hormones, thyroid)

	Hormone Name	Strength: units in mg, gm, IU, mcg	Frequency	Year Started	Year Stopped
1					
2					
3					
4					
5					
6					

\*\* Please use back of sheet if needed, and indicate that there is more hormone information of back of sheet.

List any **Nutritional/Natural Supplements** you are currently taking

	Supplement	Manufacturer	Ingredients	Strength: units in mg, gm, IU, mcg	Reason
1					
2					
3					
4					
5					
6					

\*\* Please use back of sheet if needed, and indicate that there is more medication information on back of sheet

List any **Drug/Food Allergies or Intolerances:**

	Drug/Food	Reaction
1		
2		
3		
4		
5		

\*\* Please use back of sheet if needed, and please indicate there is more allergies information on back of sheet.

**Past Surgical History:**

List hospitalizations and/or Operation due to Illness, accidents or injuries:

Date	Type of Illness, Accident or Injury	Type of Operation (if required)	Hospitalized and for how long (if required)	City/State

**Family History:**

	Alive : Yes/No	Age	If deceased, cause
<b>Birth Mother:</b>			
<b>Birth Father:</b>			
<b>Sib Brothers:</b>			
<b>Sib Sisters:</b>			
<b>Children:</b>			

Family Illnesses: (check all that apply)

	Relationship	Age Diagnosed
<input type="checkbox"/> Heart Disease	_____	_____
<input type="checkbox"/> High Cholesterol	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> Diabetes	_____	_____
<input type="checkbox"/> Breast Cancer	_____	_____
<input type="checkbox"/> Prostate Cancer	_____	_____
<input type="checkbox"/> Uterine Cancer	_____	_____
<input type="checkbox"/> Ovarian Cancer	_____	_____
<input type="checkbox"/> Glaucoma	_____	_____
<input type="checkbox"/> Alzheimer's	_____	_____
<input type="checkbox"/> Autoimmune disease	_____	_____
<input type="checkbox"/> Thyroid disease	_____	_____
<input type="checkbox"/> Weight problem	_____	_____
<input type="checkbox"/> Obesity	_____	_____
<input type="checkbox"/> Fertility Problems	_____	_____
<input type="checkbox"/> Stroke	_____	_____
<input type="checkbox"/> Osteoporosis	_____	_____
<input type="checkbox"/> Fibrocystic Breast	_____	_____
<input type="checkbox"/> Other	_____	_____

**Appetite and Digestion:**

Rapid Hungering \_\_\_\_\_ Hungry, but no desire to eat \_\_\_\_\_ Poor Appetite \_\_\_\_\_  
 Bloating \_\_\_\_\_ Nausea \_\_\_\_\_ Gas \_\_\_\_\_  
 Anorexia \_\_\_\_\_ Other \_\_\_\_\_

**Bowel/GI Health:**

# per day: \_\_\_\_\_

Constipation \_\_\_\_\_ Blood \_\_\_\_\_ Diarrhea \_\_\_\_\_ Pain \_\_\_\_\_ Loose \_\_\_\_\_  
 Reflux \_\_\_\_\_ Watery \_\_\_\_\_ Gastritis \_\_\_\_\_ Incomplete \_\_\_\_\_  
 Indigestion \_\_\_\_\_ Hard & dry \_\_\_\_\_ Full early \_\_\_\_\_ Strong Smell \_\_\_\_\_  
 Food sits in stomach \_\_\_\_\_ Mucous \_\_\_\_\_ Other \_\_\_\_\_

**Urination:**

# times/day \_\_\_\_\_ # times/night \_\_\_\_\_

Frequent \_\_\_\_\_ Foul Smell \_\_\_\_\_ Urgent \_\_\_\_\_ Blood \_\_\_\_\_ Burning \_\_\_\_\_  
 Retention \_\_\_\_\_ Pain \_\_\_\_\_ Cloudy \_\_\_\_\_ Dark color \_\_\_\_\_ Other \_\_\_\_\_

**Hydration:**

Thirsty \_\_\_\_\_ Dry mouth but no desire to drink \_\_\_\_\_  
 Dry Mouth \_\_\_\_\_ Not thirsty but drink a lot of water anyway \_\_\_\_\_  
 Drink a lot \_\_\_\_\_

**Beverage Intake:**

**Servings per day:**

Water \_\_\_\_\_  
 Coffee, Regular \_\_\_\_\_  
 Coffee, Decaf \_\_\_\_\_  
 Tea, Regular \_\_\_\_\_  
 Tea, Herbal/decaf \_\_\_\_\_  
 Pop, Regular \_\_\_\_\_  
 Pop, Diet \_\_\_\_\_  
 Juice \_\_\_\_\_  
 Milk \_\_\_\_\_  
 Sports Drink \_\_\_\_\_  
 Flavored Water \_\_\_\_\_

Alcohol: amount/frequency  
 Beer \_\_\_\_\_  
 Wine \_\_\_\_\_  
 Hard Liquor \_\_\_\_\_

Currently Smokes: amount/frequency  
 Cigar \_\_\_\_\_  
 Cigarettes \_\_\_\_\_  
 Previously smoked \_\_\_\_\_ When: \_\_\_\_\_

**Diet Strategies:**

- Balanced
- Low Carb
- Low sugar
- Ayurvedic
- Protein Fast
- High fat/high protein
- High Fiber
- Whole Foods
- Vegetarian indicate type:
- Raw Food Only
- Low calorie
- Low Sodium
- Other (Indicate type): \_\_\_\_\_

What do you routinely eat and drink for meals and snacks: (Indicate eating times)

Breakfast:

Lunch:

Dinner:

Snacks:

What time of the day are you the hungriest?

What time of the day do you experience fatigue/ malaise?

Wake-up time?

Asleep time?

**Food Choices:**

**Dairy:** Milk type \_\_\_\_\_ amount \_\_\_\_\_ day/week/month  
 Cheese type \_\_\_\_\_ amount \_\_\_\_\_ day/week/month  
 Yogurt type \_\_\_\_\_ amount \_\_\_\_\_ day/week/month

**Fats/oils:** Type of oil in cooking \_\_\_\_\_  
 Salad dressing type \_\_\_\_\_  
 Butter or Margarine \_\_\_\_\_  
 Nuts, seeds Yes/No \_\_\_\_\_  
 Nut Butter Yes/No \_\_\_\_\_  
 Fish/Seafood Yes/No Type(s) \_\_\_\_\_ How often \_\_\_\_\_

**Starches/grains:** Legumes Yes/No \_\_\_\_\_  
 Fiber Cereal Yes/No Type(s) \_\_\_\_\_ Amount \_\_\_\_\_  
 Vegetables/day \_\_\_\_\_  
 Fruits/day \_\_\_\_\_

**Respiratory health:** Seasonal Allergies \_\_\_\_\_ Sinus Problems \_\_\_\_\_  
 \_\_\_\_\_ Asthma \_\_\_\_\_

Out of breath easily \_\_\_\_\_

How often do you get a cold or flu per season? \_\_\_\_\_

Phlegm with drinking milk or eating dairy? \_\_\_\_\_

**Emotional Health and Well Being:**

Depression \_\_\_\_\_ Worries \_\_\_\_\_ Sadness \_\_\_\_\_ Overly excited \_\_\_\_\_

Panic attack \_\_\_\_\_ Angry \_\_\_\_\_ Sensitive \_\_\_\_\_ Anxiety \_\_\_\_\_

**Energy:** Normal \_\_\_\_\_ Low \_\_\_\_\_ Hyperactive \_\_\_\_\_

Up and Down \_\_\_\_\_ Nervous energy \_\_\_\_\_ Exhausted \_\_\_\_\_ Abundant \_\_\_\_\_

**Sleep Pattern:** Normal \_\_\_\_\_ Insomnia \_\_\_\_\_

**Falling Asleep:**

Sometimes difficult: \_\_\_\_\_ Always difficult \_\_\_\_\_

Sometimes very difficult \_\_\_\_\_ Always very difficult \_\_\_\_\_

Sleepy in daytime \_\_\_\_\_ Take naps \_\_\_\_\_

**Sleep Quality:** Deep \_\_\_\_\_ Light \_\_\_\_\_ Bad \_\_\_\_\_

Dreams \_\_\_\_\_ Talks in sleep \_\_\_\_\_ Bad dreams \_\_\_\_\_ Grinds teeth \_\_\_\_\_ Other \_\_\_\_\_

Wakes up: Times per night \_\_\_\_\_ Wake up too early \_\_\_\_\_ Wake up with headache \_\_\_\_\_

Awake and can't go back to Sleep \_\_\_\_\_ Awaken in the morning feeling tired \_\_\_\_\_

**Exercise History:**

Do you exercise? Yes \_\_\_\_\_ No \_\_\_\_\_

	Type of Exercise	Duration of Exercise	Frequency per week	Does this exercise make you sweat a lot?	Does it cause you pain during or after?
1					
2					
3					
4					
5					

**Body Temperature:** Normal \_\_\_\_\_ Abnormal \_\_\_\_\_  
 Feel cold easily \_\_\_\_\_ Feel hot easily \_\_\_\_\_ Alternating hot/cold \_\_\_\_\_  
 Cold hands/feet \_\_\_\_\_ Hot Flash \_\_\_\_\_ Sensitive to weather \_\_\_\_\_

**Sweating:** Normal \_\_\_\_\_ Too easily \_\_\_\_\_ Too little \_\_\_\_\_ Too much \_\_\_\_\_  
 Night sweats \_\_\_\_\_ Difficult \_\_\_\_\_ Other \_\_\_\_\_

**Sensitivities and Allergies:** Yes \_\_\_\_\_ No \_\_\_\_\_  
 Cold/Hot Temperature \_\_\_\_\_ Airborne particles \_\_\_\_\_ Damp \_\_\_\_\_ Food \_\_\_\_\_ Light \_\_\_\_\_  
 Noise \_\_\_\_\_ Easily Startled \_\_\_\_\_ Scary Movies/Violent TV are unsettling \_\_\_\_\_  
 Drugs (types)  
 \_\_\_\_\_  
 Other \_\_\_\_\_

**Skin:**

- Acne                       Cystic Acne                       Dry                       Oily                       Combination
- Flaky                       Itchy                       Eczema                       Psoriasis                       Scars
- Rosacea                       Dark Circles under eyes                       Puffy eyes                       Other

**Hair:**

- Hair loss/thinning                       Brittle                       Dull                       Eyebrow thinning (outer half)
- Eyelash length (short/long)                       Facial Hair Other

**NAILS:**

- Brittle                       White Spots                       Weak                       Other \_\_\_\_\_

**For Men:**

- Less sex drive
- Decreased strength
- Lost height
- Sad and/or grumpy
- Weaker stream
- Less strong erections
- Recent decrease in athletic ability
- Decreased enjoyment of life
- Tired after meals
- Trouble getting stream started more than 25% of time
- Less arousal
- Less stamina
- Decreased work performance
- Falls asleep after dinner
- Bladder does not feel sufficiently empty after urination
- Lack energy
- Awaken more than twice to urinate each night
- Urinate more than 5 times a day
- Experience dribble after urinating

**For Women:**

**Menstrual Cycle:** Age of onset \_\_\_\_\_ Date of last period: \_\_\_\_\_  
 Regular \_\_\_\_\_ Irregular \_\_\_\_\_

How many days per cycle? \_\_\_\_\_ How many days did it last? \_\_\_\_\_

Color:  Pale red  Bright red  Dark red  Purplish

Are there Clots? No \_\_\_\_\_ Yes \_\_\_\_\_ (if yes, explain) \_\_\_\_\_

Menstrual Pain: (Please Circle accordingly and rate pain 1 thru 10, 1 least amount 10 highest amount)

Is there pain before flow? Y / N      Abdomen      Back      Breast      Pain level \_\_\_\_\_

Is there pain during flow? Y / N      Abdomen      Back      Breast      Pain level \_\_\_\_\_

Is there pain after flow? Y / N      Abdomen      Back      Breast      Pain level \_\_\_\_\_

Emotion around period: (Please Circle accordingly)

Before flow      Normal      Depression      Irritability      Anger      Sadness      Crying

During flow      Normal      Depression      Irritability      Anger      Sadness      Crying

After flow      Normal      Depression      Irritability      Anger      Sadness      Crying

How many pregnancies have you had? \_\_\_\_\_

Have you ever had a miscarriage? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how many? \_\_\_\_\_

Did you have a tubal ligation? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what year? \_\_\_\_\_

Have you had a hysterectomy? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what year? \_\_\_\_\_

Have your ovaries been removed? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what year? \_\_\_\_\_

Did you ever have, or currently have:

- Uterine Fibroids
- Ovarian Cysts
- Endometriosis
- PCOS

**Weight History and Body Composition Pattern:**

Indicate your general tendencies:

- Always under ideal weight (eat whatever I want) don't gain weight
- Difficulty with gaining weight
- Always over ideal weight, struggled with weight control as a child, diet roller coaster
- Lose weight easily
- Overweight, and do not eat a lot
- Difficulty with maintaining weight loss
- Gain weight unintentionally
- Gain weight in the abdominal area
- Skinny arm and skinny legs
- Athletic and overweight

Highest adult weight \_\_\_\_\_ When? \_\_\_\_\_ Lowest adult weight \_\_\_\_\_ When? \_\_\_\_\_

Goal Weight \_\_\_\_\_ By when? \_\_\_\_\_

**Personal Goals:**

- Lose body fat
- Gain muscle
- Improve strength, endurance and stamina

If overweight:

- How many pounds would you like to lose? \_\_\_\_\_
- How many years ago did you first start to gain weight? \_\_\_\_\_
- Are you following a weight control program at this time? \_\_\_\_\_

What weight loss programs have your tried?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Atkins                | <input type="checkbox"/> Ornish                | <input type="checkbox"/> Weight Watchers             |
| <input type="checkbox"/> Protein Modified Fast | <input type="checkbox"/> Diabetic Exchange     | <input type="checkbox"/> Zone Diet                   |
| <input type="checkbox"/> South Beach           | <input type="checkbox"/> Carbohydrate Counting | <input type="checkbox"/> Other (indicate type) _____ |

**Weight and Body Composition:**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Weight 6 months ago \_\_\_\_\_

Weight 10 years ago \_\_\_\_\_