

**Female Health History Intake Form**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Pharmacy Name, Address, Phone: \_\_\_\_\_

Highest level of education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Hours worked per week: \_\_\_\_\_

Marital Status (circle):    Single    Married    Partner    Separated    Divorced    Widowed

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relation to Insured: \_\_\_\_\_

Does your insurance cover LabCorp or Sonora Quest? \_\_\_\_\_

Person to call in case of emergency: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Phone number for emergency contact: \_\_\_\_\_

Previous/current physician and city: \_\_\_\_\_

How did you hear of the clinic? \_\_\_\_\_

Please list any additional questions or expectations of your visit today:  
\_\_\_\_\_

**Chief Complaints**

**What are your main health concerns/reasons for your visit (please place in order of importance)**

- 1. \_\_\_\_\_ Date First Noticed or Diagnosed: \_\_\_\_\_
- 2. \_\_\_\_\_ Date First Noticed or Diagnosed: \_\_\_\_\_
- 3. \_\_\_\_\_ Date First Noticed or Diagnosed: \_\_\_\_\_
- 4. \_\_\_\_\_ Date First Noticed or Diagnosed: \_\_\_\_\_
- 5. \_\_\_\_\_ Date First Noticed or Diagnosed: \_\_\_\_\_

**List All Surgeries and Hospitalizations:**

- 1. \_\_\_\_\_ Date: \_\_\_\_\_
- 2. \_\_\_\_\_ Date: \_\_\_\_\_
- 3. \_\_\_\_\_ Date: \_\_\_\_\_
- 4. \_\_\_\_\_ Date: \_\_\_\_\_
- 5. \_\_\_\_\_ Date: \_\_\_\_\_

**List All Accidents, Injuries, Physical Traumas:**

1. \_\_\_\_\_ Date: \_\_\_\_\_

2. \_\_\_\_\_ Date: \_\_\_\_\_

3. \_\_\_\_\_ Date: \_\_\_\_\_

**Please Note When and Why You Had Each of The Following:**

X-rays: \_\_\_\_\_

MRI/Cat Scans: \_\_\_\_\_

Ultrasounds: \_\_\_\_\_

**Last time you had bloodwork done and with what doctor:** \_\_\_\_\_

**Please List All Sensitivities/Allergies/Reactions**

Drugs: \_\_\_\_\_

Foods: \_\_\_\_\_

Environment: \_\_\_\_\_

**Did you have the following: Had Disease (D), Get Immunized for it (I), or Neither (N):**

Measles:        D   I   N                      Diptheria:                D   I   N

Mumps:        D   I   N                      Tetanus:                D   I   N

Rubella:        D   I   N                      Whooping Cough:        D   I   N

Chickenpox:    D   I   N                      Hemophilus (Hib):        D   I   N

Hepatitis B:    D   I   N                      German Measles:        D   I   N

Polio:            D   I   N

Any vaccination reactions: \_\_\_\_\_

**List Yes, No, or Past regarding use of the following:**

Antacids:        Y   N   P

Steroids:        Y   N   P

Smoking:        Y   N   P        Packs per day if Yes/Past: \_\_\_\_\_

Analgesics:     Y   N   P

Laxatives:       Y   N   P

Coffee:           Y   N   P        Cups per day if Yes/Past: \_\_\_\_\_

Soda Pop:        Y   N   P        Ounces per day if Yes/Past: \_\_\_\_\_

Alcohol:         Y   N   P        How often and how much if Yes/Past: \_\_\_\_\_

Any alcohol addiction: Y N P  
 Any alcohol treatment: Y N P  
 Recreational drugs: Y N P  
 Any drugs addiction: Y N P  
 Any drug treatment: Y N P

**Family history**

	Father		Mother		Siblings		Grandparents		Spouse		Children	
Age if living	_____		_____		_____		_____		_____		_____	
Age when died	_____		_____		_____		_____		_____		_____	
Reason for death	_____		_____		_____		_____		_____		_____	
Cancer (type)	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
High Blood Pressure	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Heart Attack/stroke	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Heart disease	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Asthma/allergies	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Mental illness	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Addiction	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
TB	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Auto-immune	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Diabetes Mellitus	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Osteoporosis	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

**Any other conditions:** \_\_\_\_\_

Please give full name, dosage, how often and how long you have taken each medicine/supplement.

	<b><u>Pharmaceuticals</u></b>	<b><u>Dose</u></b>	<b><u>When/How Often</u></b>	<b><u>When Started</u></b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

	<b><u>Supplements</u></b>	<b><u>Dose</u></b>	<b><u>When/How Often</u></b>	<b><u>How Long?</u></b>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

**Review of Systems:**

Present Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Max Height: \_\_\_\_\_

Maximum Weight and when: \_\_\_\_\_

Minimum Weight and when: \_\_\_\_\_

Weight one year ago: \_\_\_\_\_ Ideal Weight: \_\_\_\_\_

**REGARDING THE NEXT SECTION: Please Circle **Y** if you have the problem **NOW**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.**

The general state of your health is:      Excellent      Good      Average      Fair      Poor

On average describe your energy level from 1 (low)-10: (high) \_\_\_\_\_

If you have fatigue, when is it the worst: morning, afternoon, evening? \_\_\_\_\_

If you have fatigue, can you do what you need to during the day?      Y      N

**Skin:**

Rash/hives:	Y	N	P	Color Change:	Y	N	P
Acanthosis Nigricans :	Y	N	P	Lump:	Y	N	P
Psoriasis/eczema:	Y	N	P	Itchy:	Y	N	P
Dry:	Y	N	P	Warts/moles:	Y	N	P
Cancer:	Y	N	P	Perspiration:	Y	N	P

**Head:**

Headache:	Y	N	P	Migraine:	Y	N	P
Dandruff:	Y	N	P	Head Injury:	Y	N	P
Oil/dry hair:	Y	N	P	Hair loss:	Y	N	P

**Eyes:**

Dry/Watery:	Y	N	P	Glaucoma:	Y	N	P
Vision changes:	Y	N	P	Cataracts:	Y	N	P
Styes:	Y	N	P	Macular Degeneration:	Y	N	P
Strain:	Y	N	P	Discharge:	Y	N	P
Itchy:	Y	N	P	Dark under eyelid:	Y	N	P

**Ears:**

Infections:	Y	N	P	Ear Wax:	Y	N	P
Hearing Loss:	Y	N	P	Tinnitus:	Y	N	P

**Nose:**

Frequent colds:	Y	N	P	Nosebleeds:	Y	N	P
Congestion:	Y	N	P	Post nasal drip:	Y	N	P
Polyps:	Y	N	P	Seasonal allergies:	Y	N	P

**Mouth/Throat:**

Canker sores:	Y	N	P	Sore throat:	Y	N	P
Cold sores:	Y	N	P	Hoarseness:	Y	N	P
Dentures:	Y	N	P	Cavities:	Y	N	P
Loss of taste:	Y	N	P	Gingivitis/Periodontal Disease:	Y	N	P

How often you do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

What type of brush do you use? \_\_\_\_\_

How often do you go to the Dentist? \_\_\_\_\_

**Neck:**

Stiffness:	Y	N	P	Swollen glands:	Y	N	P
Full movement:	Y	N	P	Tension:	Y	N	P

**Respiratory:**

Cough:	Y	N	P	TB:	Y	N	P
Wheezing:	Y	N	P	Painful breathing:	Y	N	P
Shortness of breath with exertion:	Y	N	P	Bronchitis:	Y	N	P
Shortness of breath sitting:	Y	N	P	Pneumonia:	Y	N	P
Shortness of breath lying down:	Y	N	P	Asthma:	Y	N	P

**Cardiovascular:**

High blood pressure:	Y	N	P	Rheumatic Fever:	Y	N	P
Low blood pressure:	Y	N	P	Murmurs:	Y	N	P
Arrhythmias:	Y	N	P	Palpitations:	Y	N	P
Edema:	Y	N	P	Chest pain:	Y	N	P

**Gastrointestinal:**

Heartburn:	Y	N	P	Bowel movement frequency:	_____
Indigestion:	Y	N	P	Recent change in BM:	Y N P
Bloating:	Y	N	P	Diarrhea or constipation:	Y N P
Nausea:	Y	N	P	Hemorrhoids:	Y N P
Vomiting:	Y	N	P	Gall bladder disease:	Y N P
Change in Appetite:	Y	N	P	Liver disease:	Y N P
Pancreatitis:	Y	N	P	Ulcer:	Y N P

List all travel outside the U.S. over the last five years: \_\_\_\_\_

Have you ever had food poisoning? \_\_\_\_\_

Have you noticed any of the below in your stool or toilet bowl or on toilet paper?

Blood	Mucus	Undigested Food	Black Stool	Lighter colored stool
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How many antibiotics have you had in your entire life? \_\_\_\_\_

If you are over 50 y/o, when was your last colonoscopy? \_\_\_\_\_

**Urinary Tract:**

Incontinence:	Y	N	P	Pain/burning with urination:	Y	N	P
Frequent infections:	Y	N	P	Kidney stones:	Y	N	P

Urgency: Y N P

Discharge/blood: Y N

**Female Reproductive:**

Times Pregnant: \_\_\_\_\_ Births \_\_\_\_\_ Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

Difficulty Getting Pregnant? \_\_\_\_\_

Do you do a Self Breast exam regularly? Y N How often? \_\_\_\_\_

Any breast tenderness, lumps, nipple discharge? \_\_\_\_\_

Age periods began: \_\_\_\_\_ How often periods occur? \_\_\_\_\_

How long does the period last? \_\_\_\_\_

If Menopausal, at what age did it begin? \_\_\_\_\_

Any problematic menopausal symptoms? \_\_\_\_\_

If yes, how were/are they treated? \_\_\_\_\_

**Periods:**

Heavy Bleeding: Y N P

Clotting: Y N P

Cramping: Y N P

Pain: Y N P

PMS: Y N P

Food Cravings: Y N P

Bloating: Y N P

Irritability: Y N P

Breast tenderness: Y N P

Last Pap Smear: \_\_\_\_\_

Any abnormal paps? Y N P Date if "Yes": \_\_\_\_\_

How was that treated? \_\_\_\_\_

Paps showed HPV negative: Y N Unknown

Mammography: Last Time: \_\_\_\_\_ Any Concern: \_\_\_\_\_

Dexa Bone Scan: Last Time: \_\_\_\_\_ Any Bone Loss \_\_\_\_\_

Use of Hormones: Y N P If "Yes" which ones and for What purpose: \_\_\_\_\_

Are you still on any hormones: \_\_\_\_\_

**Sexual History:**

Sexual Orientation: Heterosexual Homosexual Bi-Sexual Asexual

Sexually Active: Y N P

Healthy Libido: Y N P

Sexually Satisfied: Y N P

Painful Intercourse: Y N P

Sexually Transmitted Infection: Y N P If "yes", please list: \_\_\_\_\_

\_\_\_\_\_

What methods of birth control or safe sex practices are you currently using or interested in using?

\_\_\_\_\_

**Musculoskeletal:**

Weakness: Y N P  
Stiffness: Y N P  
Tremors: Y N P

Arthritis: Y N P  
Leg cramps: Y N P  
Pain: Y N P

**Nervous:**

Paralysis: Y N P  
Tingling/numbness: Y N P  
Seizures: Y N P  
TMJ Syndrome: Y N P

Sciatica: Y N P  
Carpal tunnel: Y N P  
Fainting: Y N P  
Disc Disease: Y N P

**Mental/Emotional:**

Which words best describe you? Please Circle

Lacking Dreams	Without Passion or Purpose	Anticipates Failure
Isolated/Lonely	Lacking Self Worth	Overly Responsible
Difficulty Letting Go	Lacking Faith	Overly Controlling
Guilty	Judgmental	Self-Critical
Frustrated/Angry	Impatient	Indecisive/No Confidence
Lacking Trust	Neurotic/Obsessive	Anxious
In A Rush	Abuse Victim	Memory Problems

**Exercise:**

Do you have any equipment at home? \_\_\_\_\_ Do you belong to a gym? \_\_\_\_\_

What is your history of exercising throughout your life? Always Active Active On/Off Never Active

What types? \_\_\_\_\_

How many days a week? \_\_\_\_\_

How long a session? \_\_\_\_\_

Hobbies: \_\_\_\_\_

**Sleep:**

How many hours per night: \_\_\_\_\_ How long does it take you to get to sleep? \_\_\_\_\_

Do you sleep through the night uninterrupted? Y N

If you wake up regularly, what is the reason? \_\_\_\_\_

Nightmares: Y N P Wake Refreshed: Y N Why not? \_\_\_\_\_

Grinds Teeth: Y N P Sleepwalk: Y N **Snores:** Y N **Apnea:** Y N Unknown

If you have been diagnosed with sleep apnea how are you treating it? \_\_\_\_\_

Nap During Day: Wants to but can't Does not need to Does nap at this time usually \_\_\_\_\_

**Food:**

Good Appetite? Y N P

Do you have constant hunger or do not feel full easily or hungry again soon after eating? Y N

Foods you crave? \_\_\_\_\_

Foods you dislike? \_\_\_\_\_

Foods that don't sit well? \_\_\_\_\_

**Toxin Exposure:**

Where were you born/lived? \_\_\_\_\_

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to? \_\_\_\_\_

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?  
\_\_\_\_\_

Have you ever had health problems when you put in new carpeting, painted your home, new cabinets, or did other refurbishing? \_\_\_\_\_

Are you particularly sensitive to perfumes, gasoline, or other vapors? \_\_\_\_\_

Do you use pesticides, herbicides, other chemicals around your home? \_\_\_\_\_

**Home Life:**

Active spiritual practice:    Y    N    P

How happy are you with the direction of your life (1 not happy - 10 Very happy)? \_\_\_\_\_

Do you have a good support network of family/friends? \_\_\_\_\_

Most Significant Relationship:        Healthy/Excellent        Unhealthy/Abusive

If abusive, list how:    Emotional        Physical        Other \_\_\_\_\_

If you have children, good relationship? \_\_\_\_\_

Do you enjoy your work? \_\_\_\_\_

How many hours do you work a week? \_\_\_\_\_

What do you do for fun /stress release? \_\_\_\_\_

How committed are you towards making valuable changes:    Somewhat        Moderately        Very