Name_____ Nickname (If preferred)_____ Date of Birth___/____/____

Age_____ Female / Male Current weight_____ one year ago_____ Maximum weight_____ Height_____

Drug allergies_____

Reasons for this visit- please include your most important health concerns in order of significance:

_____

_____

_____

List ALL <u>Prescription</u> and <u>non-prescription</u> *oral, nasal, inhaled and topical* medications with dosages as you ACTUALLY take them (250mg once daily, 100mg twice weekly, 2-3 10mg tablets 3 days a month as needed for pain/headaches, etc) **Please include medications** like Tylenol, Ibuprofen, Aspirin, Miralax, Nasal Sprays (Nasacort, Flonase, isotonic saline) skin creams/ointments/gels with the name and percentage of the active ingredient, even if you only use them occasionally. If you run out of space or time or do not understand the labeling - bring all medications with you.

_____

_____

_____

_____

List ALL supplements, herbs, vitamins, minerals, homeopathics, protein/fiber/green powders as you ACTUALLY take them. For complex formulas (more than 2 ingredients), include the BRAND and product name or bring the bottle with you.

_____

_____

_____

_____

Please circle any of the following that you use:

Coffee/black tea/cola_____ /day/wk/mo Milk(type_____) Sweetener (type_____) Flavoring(type _____)

Alcohol _____/day/wk/mo Wine/Beer/Spirits Recreational drugs_____day/wk/mo (type_____# years____)

Nicotine _____/day/wk/mo Cigarettes/Nicotine gum/Patch (_____#/day) Total # years of cigarette smoking_____

Dietary regimens or restrictions : gluten-free/wheat-free/dairy-free/vegetarian/vegan_____

_____

_____

Food allergies, sensitivities, diagnosed or suspected:_____

_____

Exercise regularly: **Yes No** Types:_____

How often?_____For how long?_____

CIRCLE symptoms you experience regularly. **Women**: X **CHECK** if they occur near or with your period where applicable.

__Irritability/anger
__Oversensitivity
__ Breast tenderness
__Low back pain
__ Pelvic cramping
__Foot/Calf cramps
__Acid reflux/heart-burn/indigestion/ burping
__Bowel irregularity
__ Hair thinning
__ Low sex drive
__Heart palpitations
__Cough/phlegm
__Often clearing throat
__Plugged ears/itchy ear ringing/buzzing
__Room goes dark
__Excessive sweating

__Fatigue
__Cry easily
__Nausea
__Acne
__Joint pain
__Pins/needles
__Headaches
__Migraines
__Neck pain
__Hemorrhoids
__Insomnia
__No sex drive
__Wheezing
__Sore throat
__Vomiting
__Vertigo
__Room spins
__Fainting
__Watery/itchy dry eyes

__Moodiness
__Memory problems
__Increased appetite
__Lowered appetite
__Muscle aches/pain
__Stiff muscles
__Sinus congestion/ runny nose/ regard-less of season ____?
__Constipation
__Can't fall asleep
__ Dark facial hair
__Chest congestion
__Choking
__Hives/itching
__Chronic Rash
__Sneezing attacks
__Sluggish/lethargy
__Chest pain
__Shortness of breath

__Anxiety/depression
__Cravings : __sweets __ chocolate __coffee
__Weight gain
__Weight loss
__Restless legs
__Abdominal bloating
__ Gas/Flatulence
__Abdominal discomfort
__ Diarrhea/loose stool
__Can't stay asleep
__ Infertility
__Bladder infections
__Urinary incontinence
__Yeast infections
__Bacterial vaginosis
__Cold sores/canker sores
__ Frequent colds/flus
__ I catch everything going around the office/school/house

__Difficulty concentrating
__Bread __salt __carbs
__Alcohol __ other_____
__Difficult to lose weight
__Difficult to gain weight
__Numbness
__Water retention:
__ in hands
__ in legs/ankles/feet
__ Light colored stool
__Night sweats
__Hot flashes
__Vaginal dryness/ itching/burning
__ Pain during sex
__ Bladder infections/ irritation after sex
__Erectile dysfunction/ poor sexual stamina

Sleep Hygiene: Use of sleep aid? **Yes No** Type_____ How often?_____

(If you use a sleep aid, please fill out according to how you sleep **with** a sleep aid, then explain in space below how you sleep **without** an aid)

# of hours per night of actual sleep on weekdays_____ on weekends_____ # of hours ALLOWED for sleep on Weekdays_____ on Weekends_____ How long does it take to fall asleep?_____Wake during the night? **Yes No**

Approx. # of times_____ How long awake during these times? Approx. _____ # of times night sweats wake you up_____ #of times you wake needing to urinate_____ I only wake up from: family/pets/noise

How is your sleep **without** an aid:_____

Use of (Circle) **TV/Computer/iPAD/Messaging device** before bed or when trying to go to sleep

Room completely dark when going to sleep (circle: street lights, floodlights, nightlights, clock lights)? **Yes No**

Wear an eye mask/earplugs? **Yes No** What time do you go to bed?_____ What time do you get up?_____

Menstrual and Reproductive History: (This page, females only)

Age of first period___ Using a birth control method now? **Yes No** Type?_____

Trying to get pregnant? **Yes No** #of pregnancies____ #of miscarriages____ #of abortions ____ #of cesareans____

#of ectopic/tubal pregnancies____ #of stillbirths____ #premature deliveries ___#of living children___ Ages_____

What birth control have you used: circle type used in the past, add year and duration: Pill_____ Depo shot_____

IUD (Mirena/other_____)_____Patch_____ Vaginal ring_____ Emergency contraception_____

Problems with any of the methods? **Yes No** If yes, please explain?_____

_____

Current or past fertility treatment? **Yes No** Past use of **bioidentical hormones**? circle all that apply, add year/duration
DHEA_____ Biest_____Estradiol_____ Estriol_____

Progesterone_____ Pregnenolone_____ Testosterone_____

_____

Have you had a hysterectomy? **Yes No** Date_____Reason?_____

Do you still have ovaries? **None One Two** Uterine Ablation? **Yes No** Date_____

Circle all that apply, current and past: Fibrocystic breasts Breast cancer Osteoporosis/Osteopenia Lichen Sclerosis

Uterine fibroids Endometrial hyperplasia Endometriosis Ovarian cysts PCOS (polycystic ovarian syndrome)

Vaginal yeast infections Bacterial vaginosis Gonorrhea Chlamydia Trichomonas Genital herpes Genital warts

Last PAP_____ Dates of abnormal results: _____ Dates of treatment _____

History of HPV ? **Yes No** Type_____ HPV Vaccine? (Gardasil) **Yes No**

For other **PMS or menstrual related symptoms** not listed or **other unique symptoms**, please list them here: _____

_____

Menstrual details: Last menstrual period (date of first day of bleeding)_____ or **# of years since last period**____

Tubal ligation? **Yes No** Date_____ how many days is your current cycle? (count from the 1st day of bleeding to

the 1st day of bleeding of the next cycle) **circle**: **<20 20-30 30-40 40-50 >50** Is your cycle predictable? **Yes no**

How many days do you bleed?_____ How many heavy days of bleeding?_____ # of **tampons** and/or **pads (circle)**

on heavy days_____/_____ on light days _____/_____

Color of flow: Bright red Dark red Light red Pink Brown **Spotting only** (circle) Do you pass **clots**? **Yes No**

Size of clots(circle): grainy pea nickel quarter golfball egg lemon How many days do you pass clots?_____

Medical History:

Surgeries, hospitalizations, Emergency room visits and other procedures(include approximate dates and chronology):

Last: Colonoscopy_____Prostate exam_____ Mammogram_____DEXA_____ EKG_____

_____ _____ _____ _____

Current Medical diagnoses: _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Personal medical history and Family medical history (blood relatives only):

	Self	Past	Family	Relation to you		Self	Past	Family	Relation
Alcoholism/drug use	___	___	___	_____	Anemia	___	___	___	_____
Asthma	___	___	___	_____	Allergies	___	___	___	_____
Arthritis	___	___	___	_____	Auto-immune disorder	___	___	___	_____
Bladder disease	___	___	___	_____	(type_____)				
Cancer	___	___	___	_____	Celiac disease	___	___	___	_____
(types_____)					Crohn's/Colitis	___	___	___	_____
Depression	___	___	___	_____	Diabetes (Type 1 type 2)	___	___	___	_____
Diverticulosis/itis	___	___	___	_____	Epilepsy/Seizures	___	___	___	_____
Gall stones/disease	___	___	___	_____	Gum disease	___	___	___	_____
Heart Disease	___	___	___	_____	High blood pressure	___	___	___	_____
Hepatitis A B C (circle)	___	___	___	_____	Kidney disease/stones	___	___	___	_____
Lung disease	___	___	___	_____	Liver disease	___	___	___	_____
Mental disorder	___	___	___	_____	Mononucelosis/EBV	___	___	___	_____
(type_____)					Obesity	___	___	___	_____
Rheumatic fever	___	___	___	_____	Stroke	___	___	___	_____
Suicide attempt(s)	#_____	___	_____		Thyroid disease	___	___	___	_____
Date(s)_____					Tuberculosis	___	___	___	_____
Tumor	___	___	___	_____	Tumor discovery date_____Treatment_____				

Other personal and family medical history not listed or previously stated_____

_____

Last dental exam_____ How often do you: Floss_____? See the dentist?_____ Metal fillings? **Yes No**

Gingivitis/periodontal disease? Yes No Root canals? **Yes No** #_____ Other_____

Immunizations: (circle) DTaP MMR Polio Varicella "Flu" (last _____) Hepatitis B Hib Pneumococcal Other_____

Additional information:_____

_____