MEDICAL HEALTH HISTORY QUESTIONNAIRE

Please complete this questionnaire as thoroughly as possible. All information is kept confidential. Please also bring results of any recent bloodwork or other health tests (stool tests, food sensitivity tests, nutrition tests, genetic tests etc.) to your visit as well.

Allergies. List all allergies including to foods, medications, herbs, supplements, dusts/environment/molds, chemicals, household items, insect stings, and indicate how each affects you:

□ No Known Allergies to Medications

Allergic to:	Symptoms:
_____	_____
_____	_____
_____	_____

Medications and Supplements. List all medications and supplements with dosage and frequency of use, e.g. magnesium 300 mg nightly.

_____	_____
Medication:	Dose & Frequency:
_____	_____
_____	_____
_____	_____
_____	_____
Supplement:	Dose & Frequency:
_____	_____
_____	_____
_____	_____

PATIENT MEDICAL HISTORY: DIAGNOSED DISEASES AND CONDITIONS

Check appropriate boxes, if any, and provide date of onset

Please list all your current and past medical diagnoses, conditions and/or symptoms with dates (if you have or have had any conditions not listed below, please list those as well): The list below may not include yours – it is just to make it easier for you to report.

GYNECOLOGICAL

- □ Endometriosis _____
- □ Fibroids _____
- □ Ovarian cysts _____
- □ PCOS _____
- □ Infertility _____
- □ Chronic yeast infections _____
- □ Chronic vaginosis _____
- □ Herpes genitalis _____
- □ Gonorrhea or Chlamydia _____
- □ Fibrocystic breasts _____
- □ Breast mass (Benign) _____
- □ Ovarian Cancer _____
- □ Breast Cancer _____
- □ Other _____

GASTROINTESTINAL

- □ Irritable Bowel Syndrome (IBS) _____
- □ SIBO _____
- □ Crohn's (IBD) _____
- □ Ulcerative Colitis (IBD) _____
- □ Gastritis or Peptic Ulcer Disease _____
- □ GERD (reflux) _____
- □ Celiac Disease _____
- □ Other _____

CARDIOVASCULAR

- □ Heart Attack _____
- □ Other Heart Disease _____
- □ Stroke _____
- □ Elevated Cholesterol _____
- □ Arrhythmia (irregular heart rate) _____
- □ Hypertension (high blood pressure) _____
- □ Rheumatic Fever _____
- □ Mitral Valve Prolapse _____
- □ Other _____

METABOLIC/ENDOCRINE

- □ Type 1 Diabetes _____
- □ Type 2 Diabetes _____
- □ Hypoglycemia _____
- □ Metabolic Syndrome _____
- □ Insulin Resistance or Pre-Diabetes
- □ Hypothyroidism (low thyroid) _____
- □ Hyperthyroidism (overactive thyroid) _____
- □ Endocrine Problems _____
- □ Polycystic Ovarian Syndrome (PCOS) _____
- □ Infertility _____
- □ Weight Gain _____
- □ Weight Loss _____
- □ Frequent Weight Fluctuations _____
- □ Bulimia _____
- □ Anorexia _____
- □ Binge Eating Disorder _____
- □ Night Eating Syndrome _____
- □ Eating Disorder (non-specific) _____
- □ Other _____

CANCER

- □ Lung Cancer _____
- □ Breast Cancer _____
- □ Colon Cancer _____
- □ Ovarian Cancer _____
- □ Prostate Cancer _____
- □ Skin Cancer _____

URINARY SYSTEMS

- □ Kidney Stones _____
- □ Interstitial Cystitis _____
- □ Frequent Urinary Tract Infections _____
- □ Other _____

MUSCULOSKELETAL/PAIN

- □ Osteoarthritis _____
- □ Fibromyalgia _____
- □ Chronic Pain _____
- □ Other _____

MEDICAL HISTORY *(CONTINUED)*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

RESPIRATORY DISEASES

- □ Asthma_____
- □ Chronic Sinusitis _____
- □ Bronchitis_____
- □ Emphysema _____
- □ Pneumonia _____
- □ Tuberculosis _____
- □ Sleep Apnea _____
- □ Other _____

SKIN DISEASES

- □ Eczema _____
- □ Psoriasis _____
- □ Acne _____
- □ Melanoma_____
- □ Skin Cancer _____
- □ Other _____

NEUROLOGIC/MOOD

- □ Depression _____
- □ Anxiety _____
- □ Bipolar Disorder _____
- □ Schizophrenia _____
- □ Headaches _____
- □ Migraines _____
- □ ADD/ADHD_____
- □ Autism _____
- □ Mild Cognitive Impairment _____
- □ Memory Problems _____
- □ Parkinson's Disease _____
- □ Multiple Sclerosis _____
- □ ALS _____
- □ Seizures_____
- □ Other Neurological Problems _____

Additional Health History

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- □ Full Physical Exam _____
- □ Colonoscopy _____
- □ Cardiovascular tests_____
- □ Hemoccult Test-*stool test for blood* _____
- □ Other _____

SIGNIFICANT INJURIES

Injury:	Date:

SURGERIES

Check box if yes and provide date of surgery .

- □ Appendectomy _____
- □ Hysterectomy +/- Ovaries _____
- □ Gall Bladder _____
- □ Hernia _____
- □ Tonsillectomy _____
- □ Dental Surgery _____
- □ Breast implant _____
- □ Female reproductive surgery _____
- □ Joint Replacement –Knee/Hip _____
- □ Heart Surgery_____
- □ Pacemaker _____
- □ Plastic surgery _____
- □ Other _____
- □ None _____

HOSPITALIZATIONS

Date:	Reason:

ADDITIONAL GYNECOLOGIC HISTORY

OBSTETRIC HISTORY (*Check box if yes and provide number)*

□ Pregnancies_____ □ Caesarean_____ □ Vaginal deliveries_____
□ Miscarriage_____ □ Abortion_____ □ Living Children_____
□ Post-Partum Depression □ Eclampsia □ Gestational Diabetes □ Baby Over 8 Pounds
□ Breast Feeding. For how long?_____
□ Fertility treatment in the past? _____
□ Dates of pregnancies: _____

MENSTRUAL HISTORY AND BIRTH CONTROL

Age First Period:_____ Days Between Cycles:_____ # Days of Bleeding _____
Is your period: □Heavy □Medium □Light #pads/tampons/cups per day?_____ (circle which)
Is your period extremely painful? □ Yes □ No
Has your period ever skipped? If so, when: _____ For how long? _____
Date of Last Menstrual Period: _____

Use of hormonal contraception in the past:
□ Birth Control Pill □Patch □ Nuva Ring □ IUD (progestin) □ IUD (copper)
Age started to use: _____ Reason: _____
How long? _____

Female Sexual Habits:
☐ Currently sexually active ☐ with one partner ☐ with multiple partners
☐ Not currently sexually active

Current Birth Control Method:
□ Abstinence □ Birth control pill □ IUD (copper or Progestin) □ Nuva Ring □ Patch
□ Condoms _____ □ Tubal Ligation □ Partner Vasectomy □ Depo Shot □Withdrawal
□ Foams/Jellies/Sponge □ Diaphragm □ Cervical Cap □ Fertility Awareness Method

FEMALE WELLNESS HISTORY

Last Mammogram:_____ Breast Biopsy/Date:_____
Last PAP Test:_____□ Normal □ Abnormal
Last Bone Density:_____Results: □ High □ Low □ Within Normal Range

If you are in menopause: When was last period?:_____
Please check any of the following symptoms that apply:
□ Hot Flashes □ Night Sweats □Mood Swings □ Concentration/Memory Problems
□ Vaginal Dryness □ Decreased Libido □ Difficulty Sleeping
□ Joint Pains □Headaches □ Weight Gain
□ Urinary Incontinence □Palpitations

□ Use of hormone replacement therapy? How long?_____

Any other treatments tried for any of the above problems? If yes, please describe.

_____
_____

FAMILY HISTORY

Check family members that apply.	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNTS	UNCLES	OTHER
Age (if still alive)												
Age at death (if deceased)												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes – Type 1 or Type 2												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Hyperthyroidism / Grave's Disease												
Hypothyroidism or Hashimoto's												
Irritable Bowel Syndrome												
IBD (Crohn's or Ulcerative Colitis)												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease Other:												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? □ Yes □ No
Have you made any changes in your eating habits because of your health?
□ Yes □ No Describe:_____
Do you currently follow a special diet or nutritional program? □ Yes □ No

Check all that apply:
□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy
□ No Wheat □ Gluten Restricted □ Vegetarian □ Vegan □ Keto Diet
□ Specific Program for Weight Loss/Maintenance Type: _____
□ Other _____
Do you avoid any particular foods? □Yes □No
If yes, types and reason _____
_____

If you could only eat a few foods a week, what would they be? _____
_____

Do you crave any specific foods?_____

Coffee cups/day: □1 □2-4 □> 4 |
Soda or Diet Sodas Intake: □ Yes □ No If yes, which one and how many? _____

Do you avoid artificial sweeteners (Splenda, NutraSweet, Equal, other): □ Yes □ No

Please list typical foods consumed daily – specify typical times of day for each:

Breakfast	
Lunch	
Dinner	
Snacks	
Sweets	
Water	How much? Tap, filtered, bottled?

SMOKING

Currently Smoking tobacco? □ Yes □ No
How many years? _____Packs per day: _____Attempts to quit:_____
Previous Smoking: How many years? _____Packs per day? _____
Second Hand Smoke Exposure? □ Yes □ No
Currently Smoking E-Cigarettes? □ Yes □ No

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*
□ None □ 1-3 □4-6 □ 7-10 □> 10 *If "None," skip to Other Substances*

OTHER SUBSTANCES

Are you currently using any recreational drugs? □ Yes □ No
Type_____
Have you ever used IV or inhaled recreational drugs? □ Yes □ No

EXERCISE

Current Exercise Program: *(List type of activity, number of sessions/week, and duration)*

Activity	Type	Frequency per Week	Duration in Minutes

Rate your level of motivation for including exercise in your life? 1 Low 2 Medium 3 High
List problems that limit activity:

_____
_____

SLEEP/REST

What time do you go to bed? _____ What time do you wake?_____
Do you have trouble falling asleep? □ Yes □ No
How long does it take you to get to sleep:_____
Number of times you wake in the night:_____
Can you go back to sleep if you wake before morning? □ Yes □ No
Do you feel rested in the morning? □ Yes □ No
Do you snore? □ Yes □ No
Do you use sleeping aids (medications or supplements)? □ Yes □ No
Explain: _____

OCCUPATION

What is your occupation (including full-time mother/CEO of home)? _____
Number of hours worked per week: _____
Do you like your work? _____
Do you like your work environment? □ Yes □ No If no, please explain: _____
_____

ROLES/RELATIONSHIP

Relationship status (check all that apply):
□ Single □ Married □ Divorced □ Gay/Lesbian □ Long Term Partnership □ Widow

Please List Children if you have any:

Age	Gender

Who is Living in Household? _____

Resources for emotional support?
Check all that apply:
□Spouse □Family □Friends □Religious/Spiritual □Pets □Other: _____
Are you satisfied with the current status of your sex life? □ Yes □ No

PSYCHOSOCIAL / STRESS / SPIRITUAL PRACTICES / SENSE OF WELL-BEING

Do you feel you have an excessive amount of stress in your life? □ Yes □ No
Do you feel you can easily handle the stress in your life? □ Yes □ No

Daily Stressors: Rate on scale of 1-10 (1 = very low, 10 = very high
□ Work □ Family □ Social Health □ Finances □ Other _____

Do you have a practice to cope with stress? _____

Do you practice meditation or relaxation techniques? □ Yes □ No How often? _____
Check all that apply: □Yoga □Meditation □Imagery □Breathing □Tai Chi □Prayer
□Other: _____

Would you describe your experience as a child in your family as happy and secure? □ Yes □ No
Have you ever been abused, a victim of a crime, or experienced a significant trauma? □ Yes □ No

Do you feel your life has meaning and purpose? □ Yes □ No

Have you ever sought counseling? □ Yes □ No
Are you currently in therapy? □ Yes □ No

Do you have any spiritual practices you follow? □ Yes □ No

If yes, please describe: _____

Do you do anything else to regularly support your health and well-being?

SYMPTOM REVIEW

Please check all current symptoms or those present in during the past the 3 months.

GENERAL/ENDOCRINE
- □ Fatigue
- □ Cold Hands & Feet
- □ Cold Intolerance
- □ Heat Intolerance
- □ Low Body Temperature
- □ Low Blood Pressure
- □ Fever
- □ Excessive Thirst
- □ Loss of Appetite
- □ Hypoglycemia (need to eat often or feel weak, irritable, shaky)
- □ Unintentional weight gain
- □ Unintentional weight loss
- □ Difficulty losing weight

HEAD, EYES, EARS, NOSE
- □ Headache
- □ Migraine
- □ Dry eyes
- □ Eye crusting
- □ Eye pain
- □ Vision problems (other than glasses/contacts)
- □ Ear Fullness
- □ Ear Pain
- □ Ear Ringing/Buzzing
- □ Hearing Loss
- □ Sensitivity to Loud Noises
- □ Nasal Stuffiness
- □ Nose Bleeds
- □ Post Nasal Drip
- □ Sinus Fullness/Pressure
- □ Sinus Infection
- □ Nasal congestions
- □ Distorted Sense of Smell

Hay Fever:
- □ Spring
- □ Summer
- □ Fall

IMMUNE SYSTEM
- □ Frequent colds/flus
- □ Frequent antibiotic use
- □ Swollen lymph nodes
- □ Night sweats

RESPIRATORY
- □ Cough-Dry
- □ Cough-Productive
- □ Hoarseness
- □ Wheezing

MOOD/NERVES
- □ Agoraphobia
- □ Anxiety
- □ Depression

Difficulty:
- □ Concentrating
- □ With Balance
- □ With Thinking
- □ With Judgment
- □ With Speech
- □ With Memory

- □ Dizziness (Spinning)
- □ Fainting
- □ Fearfulness
- □ Irritability
- □ Light-headedness
- □ Numbness
- □ Tingling
- □ Tremor
- □ Other Phobias
- □ Panic Attacks
- □ Seizures
- □ Suicidal Thoughts
- □ Visual Hallucinations

SKIN, HAIR, NAILS
- □ Acne
- □ Itching skin
- □ Dry skin
- □ Rash
- □ Bumps on Back of Upper Arms
- □ Cellulite
- □ Easy Bruising
- □ Lack of Sweating
- □ Eczema
- □ Hives
- □ Psoriasis
- □ Athlete's Foot
- □ Jock Itch
- □ Moles w/Color/Size Change
- □ Red Face
- □ Skin Darkening
- □ Melasma
- □ Strong Body Odor
- □ Vitiligo
- □ Nail thickening
- □ Nail pitting
- □ Dandruff / Flaky Scalp
- □ Hair loss
- □ Male pattern hair growth in female (upper lip, chin, etc.)

DIGESTION
- □ Acid reflux / heartburn
- □ Ulcer (s)
- □ Abdominal pain
- □ Abdominal bloating

Bloating of:
- □ Lower Abdomen
- □ Whole Abdomen
- □ Bloating After Meals

- □ Burping / belching
- □ Excess Flatulence/Gas
- □ Nausea
- □ Vomiting
- □ Constipation
- □ Diarrhea
- □ Alternating Diarrhea and Constipation
- □ Blood in stools
- □ Hemorrhoids
- □ Fissures
- □ Itching anus
- □ Rectal pain/bleeding
- □ Canker Sores
- □ Cold Sores
- □ Cracking at Corner of Lips
- □ Difficulty Swallowing
- □ Dry Mouth

EATING/EMOTIONS:
- □ Binge Eating
- □ Bulimia
- □ Fear of certain foods

CARDIOVASCULAR
- □ Chest pain
- □ Shortness of breath
- □ Heart Murmur
- □ Heart rhythm abnormalities
- □ Palpitations / "Flutters"
- □ Poor circulation: cold hands/feet
- □ Swollen Ankles/Feet
- □ Varicose Veins

MUSCULOSKELETAL
- □ Joint Pain
- □ Joint Stiffness
- □ Muscle Pain
- □ Muscle Spasms
- □ Muscle Stiffness
- □ Restless legs
- □ Leg cramps

URINARY

- □ Frequent Urination
- □ Urgency
- □ Urinary incontinence/Leaking
- □ Urinary tract infections
- □ Hesitancy (trouble getting started)
- □ Pain/Burning

MALE REPRODUCTIVE

- □ Discharge From Penis
- □ Ejaculation Problem
- □ Genital Pain
- □ Impotence
- □ Prostate or Urinary Infection
- □ Lumps In Testicles
- □ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- □ Breast Cysts
- □ Breast Lumps
- □ Breast Tenderness
- □ Ovarian Cyst
- □ Poor Libido (Sex Drive)
- □ Vaginal Discharge
- □ Vaginal Odor
- □ Vaginal Itch
- □ Vaginal dryness
- □ Vaginal Pain with Sex
- □ Frequent yeast infections
- □ Frequent bacterial vaginosis

Premenstrual:

- □ Bloating
- □ Breast Tenderness
- □ Fatigue
- □ Back aches
- □ Irritability
- □ Weepiness
- □ Depression
- □ Sugar cravings

Menstrual:

- □ Cramps
- □ Heavy Periods
- □ Irregular Periods
- □ No Periods
- □ Scanty Periods
- □ Spotting Between

SPACE FOR ADDITIONAL NOTES

Please list anything that you would like to share that was not covered above.