Female Health History Intake Form

Patient Name: ______________________________ Date: DOB: ______________ Age: ___________

Street Address: ____

City: ______________________________ State: ____________ Zip: ______________________

Home phone: _______________ Work Phone: _______________ Cell Phone: ____________________

Email: ____

PharmacyName, 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 SonoraQuest? _____________________________________

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.

Pharmaceuticals	Dose	When/How Often?	When Started?
1. ____________________	__________	____________	__________
2. ____________________	__________	____________	__________
3. ____________________	__________	____________	__________
4. ____________________	__________	____________	__________
5. ____________________	__________	____________	__________
6. ____________________	__________	____________	__________

Supplements	Dose	When/How Often?	How Long?
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

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
Irrita bility:	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	-Bisexual	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	Arthritis:	Y N P
Stiffness:	Y N P	Leg cramps:	Y N P
Tremors:	Y N P	Pain:	Y N P

Nervous:

Paralysis:	Y N P	Sciatica:	Y N P
Tingling/numbness:	Y N P	Carpal tunnel:	Y N P
Seizures:	Y N P	Fainting:	Y N P
TMJ Syndrome:	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