General Health History Questionnaire

(To be completed by patient)

Name: ______________________________ Date: ______________

Date of Birth: _____________ Age: _______ Sex: M / F (circle one)

Weight: _________ Height: _________

Chief Complaint(s):

____

____

____

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

- □ Antacids, Zantac, Pepcid AC, Rolaids, etc.
- □ Chemotherapy
- □ Laxatives
- □ Ulcer Medications
- □ Antibiotic/Antifungal
- □ Anti-diabetic/Insulin
- □ Oral Contraceptives
- □ Relaxants/Sleeping Pills
- □ Thyroid
- □ Radiation
- □ Antidepressants
- □ Aspirin/Acetaminophen
- □ Cortisone/Anti-Inflammatory
- □ Heart Medications
- □ High Blood Pressure Medicine

□ Hormones – If so, what? ____________________ When? ____________ Dosage? _________

Please list names of any medications you are currently taking:

____

____

____

Are you allergic to any drugs that you know of? (if so please list names):

____

____

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking:

____

____

____

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Lifestyle

Dietary Habits: Describe the foods you normally eat:
BREAKFAST: ______
LUNCH: ______
DINNER: ______
SNACKS: ______

Do you consume the following?			If so, how much?
1. Soda or carbonated beverages?	YES	NO	______
2. White flour products?	YES	NO	______
3. Fried foods?	YES	NO	______
4. Coffee?	YES	NO	______
5. Fast foods regularly?	YES	NO	______
6. Sweets and/or refined carbohydrates?	YES	NO	______
7. Alcoholic beverages?	YES	NO	______
8. Any tobacco products?	YES	NO	______

Are you a vegetarian? Y YES NO

Are you currently involved in an exercise program? YES NO How often? ______
How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
How do you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

Males Only

Have you had a vasectomy? YES NO When? ______
Reverse vasectomy? YES NO When? ______
Experienced any symptoms related to the vasectomy? YES NO
If so, please explain: ______
______

Do you have any history of prostate problems? YES NO
If so, please explain: ______
______
When was your last prostate exam? ______
What were your most recent PSA results? ______ Date ______

Does your bladder always feel full?	YES	NO	SOMETIMES
Do you experience inconsistent pressure or pain during urination?	YES	NO	SOMETIMES
Does ejaculation cause pain?	YES	NO	SOMETIMES
Do you experience low sex drive?	YES	NO	SOMETIMES
Do you have premature ejaculation?	YES	NO	SOMETIMES

All men completing this form should now skip to the bottom section of page 6 labeled "sleep" and continue on with the remainder of this questionnaire.

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Females Only – Reproductive Health History *(to be completed by all women)*

Age at onset of first period: ______ Approximate date of onset: ______

What are you using for contraception at the moment? ________________________________

Have you ever used ***oral*, *injected*, *patch*, or *ring*** hormone contraceptives, or used *Emergency Contraception ("the day after" pill)?* YES NO
From ______________to_______________
Did you suffer from any side effects? YES NO Explain: ________________________________

Are you currently or have you ever used and IUD? YES NO
When? ________________________ For how long? ____________________________

While under the use of any and all birth control methods, did you experience the following? Y*east, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.* ***(Please circle and use extra space provided if explanation is needed)***

____

____

____

Are you currently, or have you ever used fertility treatment? YES NO
If yes, please explain. ____

____

Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc.? YES NO

If yes, what hormone(s), dosage and for how long? **Please be specific with dates of use.**

____

____

Do you have any history of abnormal Pap Tests? YES NO
If yes, please explain: ____
Please describe any treatment and/or medication for this: ______________________________

Do you have any history of vaginal infections? YES NO
If yes, please describe: ____
Please describe any treatment and/or medication for this: ______________________________

Do you have any history of the following conditions? (*Please circle appropriate answer)*
Ovarian Cysts, Fibrocystic Breasts, Polycystic Ovarian Syndrome (PCOS), Uterine Fibroids, Endometriosis, Lichen Sclerosis, Vulvodynia

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Pregnancy History *(to be completed by all women, if applicable)*

Have you been pregnant before? YES NO
Please list the age(s) of your children:
____

Please explain important details/complications below:

Number of pregnancies: ______ ____
Number of live births: ______ ____
Number of miscarriages: ______ ____
How many weeks gestation at the time of miscarry? _____ Weeks
Number of premature births: ______ ____
Number of cesarean births: ______ ____
Number of stillbirths: ______ ____
Number of ectopic pregnancies: ______ ____

All menopausal women should now skip to the bottom section of page 5 labeled "menopausal women" and continue on with the remainder of this questionnaire.

Cycling History *(to be completed by all women who have not reached menopause)*

What was the first date of your last menstrual period (LMP)? ________________________________

Have you ever had tubal ligation surgery? YES NO
If so, please list the date and specific details: ____
____

Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle? *(Please circle appropriate answer)*
<20 days 20-30 days 30-40 days 40-50 days >50 days

What is the length of days your menstruation typically lasts? _____________

Do you consider your cycle to be regular? YES NO Not Always
Details: ____

What is your typical menstrual flow like? Light Medium Heavy
Details: ____

How many pads and/or tampons *(circle)* do you use on heavy days? __________
During menstruation, do you pass blood clots? YES NO How often? __________________

How would you describe your cramping? None Mild Moderate Severe
At what point in your cycle? ____

Cycling History, Cont'd *(to be completed by all women who have not reached menopause)*

Have you noticed any recent changes to your cycle? If yes, explain: ______________________

During menstruation do you experience any vaginal discharge? YES NO
When? ____________________________

Do you ever experience itching or odor in the vaginal area? YES NO
When? ____________________________

Do you experience any breast tenderness? None Mild Moderate Severe
If yes, at what point in your cycle? ____

Do you have nipple discharge at any point in your cycle? YES NO
If yes, at what point in your cycle? ___________________________ Color? ____________________

All cycling women should now skip to the bottom section of page 6 labeled "sleep" and continue on with the remainder of this questionnaire.

Menopausal Women

What age were you at the onset of menopause? __________ Year of onset? _________

Please describe any recent changes and/or symptoms associated with your cycle:
____
____
____

Please list any and all GYN surgeries:	What was the reason for each surgery?
1. ____________________________	____
2. ____________________________	____
3. ____________________________	____
4. ____________________________	____
5. ____________________________	____

Please give an in depth explanation of how you perceive your experience transitioning into menopause: *(for example, please list symptoms, emotional changes, thoughts, stressors, etc.)*
____
____
____

Are you currently, or have you ever used conventional hormone replacement (HRT)? ______
If yes, please list the name of the prescription: ____
What is/was the dosage? ______________________ For how long? __________________________

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Menopausal Women Continued…

Are you currently, or have you ever used bio-identical hormone creams/gels/sublingual, troche, oral? YES NO
If yes, please list the name(s) of each product: ______________________
What is/was the dosage? ____________ For how long? ______________

Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? YES NO
If yes, please list the name(s) of each product: ______________________
What is/was the dosage? ____________ For how long? ______________

Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? YES NO
If yes, what? ______________________________________
Treatment: ______________________________________

Below please describe your cycle history.

Would you have described your menstruation as: Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling would you describe your cycle as regular? YES NO
If no, please give explanation: ______________________________
____

In the past, if you have ever received any type of "treatment" for any cycle issues would you please explain: ______________________________
____
____

Sleep

How well do you sleep?
□Well □ Trouble falling asleep □ Trouble staying asleep □ Insomnia

What is the average number of hours you most often sleep each night? ________
Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO
If yes, how often? ______________________________

Do you keep your room completely dark at night? YES NO

<u>Signs & Symptoms</u> *(INSTRUCTIONS: Circle the number that best describes the intensity of your <u>current</u> symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.*

Section 1:			
Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestion?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/Nausea? (circle)	1	2	3

Section 2:			
Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
IBS?	1	2	3
Persistent Gas?	1	2	3
Digestive problems?	1	2	3

Section 3:			
Low blood sugar / hypoglycemia?	1	2	3
Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine/stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

Section 4:			
Low mood/depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

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<u>Signs & Symptoms, Cont'd</u> *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.*

Section 5:			
Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships? (circle)	1	2	3
Decreased initiative/motivation/drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:			
Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness/crying? (circle)	1	2	3

Section 7:			
Decrease in strength/stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decreased lean muscle mass?	1	2	3
Muscle soreness/weakness? (circle)	1	2	3
Body/joint aches? (circle)	1	2	3
Increased fat on hips/breasts/thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:			
Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/Migraines? (circle)	1	2	3
Muscle pain/Joint aches/Backache? (circle)	1	2	3

Section 9:			
Head hair loss/body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

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Signs & Symptoms, Cont'd *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens approximately weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.*

Section 10: ***(females only)***			
Infertility?	1	2	3
Lowered/Heightened libido? (circle)	1	2	3
Hot flashes?	1	2	3
Night sweats?	1	2	3
Palpitations?	1	2	3
Breast tenderness?	1	2	3
Breast cysts?	1	2	3
Vaginal infections/Yeast infections? (circle)	1	2	3
Urinary Frequency/Incontinence/Infections? (circle)	1	2	3
Changes to labia/clitoral tissue			
(Atrophy, thinning, discoloration, itching, burning)? (circle)	1	2	3
Vaginal changes (dryness, tearing, decreasing size)? (circle)	1	2	3
Bone loss/osteoporosis?	1	2	3
Endometriosis?	1	2	3
Pelvic Inflammatory Disease?	1	2	3
Cystitis?	1	2	3
Ovarian cysts?	1	2	3
Fibroids?	1	2	3

Section 11: ***(males only)***			
Lowered libido?	1	2	3
Erectile Dysfunction (ED)?	1	2	3
Pain w/ ejaculation?	1	2	3
Frequent need to urinate?	1	2	3
Urination is delayed/strained/incomplete? (circle)	1	2	3
Pain with urination?	1	2	3
Blood in the urine?	1	2	3
Bone loss/osteoporosis?	1	2	3

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