CENTER FOR HEALTHY LIVING

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Adult Female Questionnaire

Today's Date: _____/_____/_____ BLOOD TYPE:______________

Patient Name: ____________________________ Birth date: ____/____/____ Age:_______

Address: ____

City: ____ State: ________ Zip: ________

Home Phone: _____________________Cellular_________________Work:_______________

Email: ________________________

Type of Health Insurance: BCBS PPO____ HMO____ Other_______________________

Occupation:___________________________________ Social Security #_________________

Previous Occupations: ____

Single_____ Married_____ Widowed_____ Divorced_____

Are you now or have you ever been in a personal relationship that causes you pain, fear or injury? ____

Height: _______ Weight: ________

- Do you use tobacco? _____ Yes How much per day?__________________ _____ No
- Do you use alcohol? _____ Yes How much per day?__________________ _____ No
- Do you use caffeine? _____ Yes How much per day?__________________ _____ No
- Tea, Coffee or Chocolate? ____
- **Do you use artificial sweeteners? _____ Yes What type?_______________ _____ No**
- Do you drink carbonated beverages?_____ Yes How many per day? _________ _____ No
- Do you have any pets?_____ Yes Type? ___________________________ _____ No
- Have you lived or traveled outside of the United States?
  If so, when and where?

Allergies: Please check all that apply

_____ Penicillin _____ morphine _____ dye allergies _____ seasonal (pollen) allergies
_____ Codeine _____ aspirin _____ nitrate allergy _____ no known allergies
_____ sulfa drugs _____ food allergies _____ pet allergies _____ other: ______________________

Please describe the allergic reaction you experienced and when it occurred: ___________________________
____

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

_____ pain reliever
_____ aspirin
_____ acetaminophen (Tylenol®)
_____ ibuprofen (Motrin IB®)
_____ naproxen (Aleve®)
_____ ketoprofen (Orudis KT®)
_____ cough suppressant (Robitussin DM®)
_____ antihistamine (Benadryl, Chlor-Trimeton®)
_____ decongestant (Sudafed®)
____ combination products (cough & cold reliever, Triaminic DM®)
____ sleep aids (Excedrin PC®, Unisom®, Sominex®, Nytol®)
____ antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)
____ Laxatives / stool softener (Doxidan®, Correctol®)
____ Diet aids / weight loss products (Dexatrim®
____ antacids (Maalox®, Mylanta®)
____ acid blockers (Tagamet HB®, Pepcid C®, Zantac 75®)
____ others: ______________________________

Vitamin/Mineral Supplement Name **Date Started** **Dosage**

____
____
____
____
____
____

Describe your eating habits including the times you usually eat: (include deserts)

Breakfast **Lunch** **Dinner** **Type of Snacks**

____
____
____
____
____
____

What foods to you crave?

____

Medical Conditions / Diseases: Please check all that apply to you.

_____ Heart disease
_____ High cholesterol or lipids (e.g. hyperlipidemia)
_____ High blood pressure (e.g. hypertension)
_____ Cancer
_____ Ulcers (e.g. stomach, esophagus)
_____ Thyroid disease
_____ Hormonal related issues
_____ Lung conditions (e.g. asthma, emphysema, COPD)
_____ ***Other:***

____ Blood clotting problems
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye disease (e.g. glaucoma, etc.)
____ Thyroid disease - goiter, nodules, low thyroid

Please describe any past medical history:

____
____
____
____

Past Surgeries:

Current Prescription Medications:

Medication Name Reason for Taking? Strength Date Started

____

____

____

____

____

How often have you taken antibiotics? ______________________________________

Hormones previously taken Date Started Date Stopped Reason

____

____

____

Have you ever used oral contraceptives? ____ Yes _____ No
For how long and when? ____
If yes, any problems using oral contraceptives? ____ Yes _____ No
Please describe:

____

How many pregnancies have you had? _____ How many children? _____
Any interrupted pregnancies? _____ No _____ Yes
Have you had a hysterectomy? _____ No _____ Yes (date of surgery) ___________
Ovaries removed? _____ No _____ Yes
Have you had a tubal ligation? _____ No _____ Yes
Describe any other surgeries: ____

____

Dental History
How many Silver/Mercury Amalgams do you have? ___________________
Recent cavities, crowns, root canals? Describe:___________________________________

____
History of any Gum Disease? Describe:____

Do you have a family history of any of the following?

Uterine cancer _____ No _____ Yes Family member(s) __________________
Ovarian cancer _____ No _____ Yes Family member(s) __________________
Breast cancer _____ No _____ Yes Family member(s) __________________
Other Cancers _____ No _____ Yes Family member(s) __________________
Heart disease _____ No _____ Yes Family member(s) __________________
Osteoporosis _____ No _____ Yes Family member(s) __________________
Diabetes _____ No _____ Yes Family member(s) __________________
Hypertension _____ No _____ Yes Family member(s) __________________
Alergies/Asthma _____ No _____ Yes Family member(s) __________________
Alzeimer's/Dementia _____ No _____ Yes Family member(s) __________________
Eczema _____ No _____ Yes Family member(s) __________________

Any other family history we should know about?

Have you had any of the following tests performed?

Mammogram	_____ No	_____ Yes	Date:___________	Result: ________________________
Pap Smear	_____ No	_____ Yes	Date: ___________	Result: ________________________
Bone Densitometry	_____ No	_____ Yes	Date: ___________	Result: ________________________

When was the date your last cycle? ________________________

How many days did it last? ________________________

Describe any change in your cycles for the past two years:

____

____

Please indicate your symptoms for the following conditions:

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	________	________	___________	________
Uterine Fibroids	________	________	___________	________
PMS (Pre-menstrual Syndrome)	________	________	___________	________
Weight Gain	________	________	___________	________
Carbohydrate Craving	________	________	___________	________
Chocolate Craving	________	________	___________	________
Constipation	________	________	___________	________
Heavy/Irregular menses	________	________	___________	________
Hot Flashes	________	________	___________	________
Dry Skin / Hair	________	________	___________	________
Anxiety	________	________	___________	________
Depression	________	________	___________	________
Night Sweats	________	________	___________	________
Vaginal Dryness	________	________	___________	________
Headaches/Migraines	________	________	___________	________
Irritability	________	________	___________	________
Mood Swings	________	________	___________	________
Breast Tenderness	________	________	___________	________
Sleep Disturbances / Insomnia	________	________	___________	________
Cramps	________	________	___________	________
Fluid Retention	________	________	___________	________
Breakthrough Bleeding	________	________	___________	________
Fatigue	________	________	___________	________
Ovarian Cysts	________	________	___________	________
Endometriosis	________	________	___________	________
Memory Loss	________	________	___________	________
Incontinence/frequent urination	________	________	___________	________
Arthritis	________	________	___________	________
Difficulty reaching orgasm	________	________	___________	________
Decreased libido	________	________	___________	________
Hair Loss	________	________	___________	________
Thyroid Goiter	________	________	___________	________
Heartburn/Indigestion	________	________	___________	________
Diarrhea	________	________	___________	________
Gas/Bloating	________	________	___________	________

Do you have any risk factors for blood clots? *(circle ones below)*

- **Cancer**
- **Prior blood clot (DVT)**
- **Advanced age**
- **Restricted mobility longer than 3 days**
- **Inherited clotting disorder**
- **Overweight**
- **Recent hospitalization**
- **Major surgery in previous 4 weeks**
- **Pregnancy or post partum**
- **Long plane or car trips (>4 hours) in previous 4 weeks**
- **Using birth control pills**
- **Take menopausal hormones by mouth**
- **Recent trauma**
- **Stroke**
- **Heart attack**
- **Heart Failure**
- **Nephrotic syndrome**
- **Ulcerative colitis**
- **Lower extremity fractures**
- **Systemic lupus erythematosus (SLE)**
- **Behcet syndrome**

Lifesyle Questions

1. How often do you exercise?____

2. During the past 12 months, how often have you felt excessive stress in your life?

Never_____ Occasionally_____ Often_____ Almost always_____

Have you experienced any major losses in life? Yes____ No____

If so, please comment:

3. How would you describe your health?

Excellent_____ Very good_____ Good_____ Fair_____ Poor_____

How did you arrive at the decision to consider see an Anti-Aging / Functional Medicine Specialist?

_____ Doctor _____ Self _____ Friend/family member _____ Other

Please Describe:____

____

Describe your problems that lead you to this consultation:

What are your goals with this consultation?

Please write down any specific questions you may have.

How did you hear about us?

At a lecture: where?

Referral?

From a compounding pharmacy?

Do you presently get prescriptions at a compounding pharmacy?

If possible, bring in any recent lab work or other test results. Thank you!