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

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!