

Patient Name _____ DOB _____

Name _____ Today's date _____

Date of birth _____ Age _____ Sex: Male Female Blood Type _____

Context of Care

Why did you choose to come to this clinic, and what do you know about our approach? _____

Health Concerns

Please list your main health concerns in order of importance.

1. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

2. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

3. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

4. Describe your condition _____

When did it start? _____

Has this condition been diagnosed? yes no Diagnosis _____

Are you currently receiving any treatment for this condition? *Please describe:* _____

What would you most like to accomplish on your **first visit**? _____

What long-term expectations do you have from working with us? _____

Healthcare History and Providers Information

Who is your primary care physician? _____

When was your last physical exam? (Month/year) _____

Blood work / Lab work (Month/year) _____

Who is your dentist? _____
(Name) (Address/ Phone)

When was your last dental visit? (Month/year) _____

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Who is your optometrist? _____
(Name) (Address/Phone)

When was your vision last checked? (Month/year) _____

Are you currently under the care of or seeing a specialist? *Please provide Name, Address and Phone*

1: _____

2: _____

3: _____

Have you had any of the following in the last ten years?

| Test | When For what reason? | Result Outcome |
|---------------------|-----------------------|------------------|
| Bone Density (DEXA) | | |
| CT scan | | |
| Colonoscopy | | |
| EKG | | |
| Endoscopy | | |
| MRI | | |
| Ultrasound | | |
| X-ray | | |

Are you currently under the care of an alternative healthcare provider (i.e.: Acupuncturist, chiropractor, massage therapist)?

Please provide Name, Address and Phone

1: _____

2: _____

Past Medical History

List any medical conditions you have experienced (*i.e.: Diabetes, Cancer, Epilepsy, High Blood Pressure*)

| Procedure | Year |
|-----------|------|
| | |
| | |
| | |
| | |

Hospitalizations / Surgeries (*including Tonsils, Gallbladder, Appendix, Cosmetic*)

| Procedure | Year |
|-----------|------|
| | |
| | |
| | |
| | |

Major Injuries

| Accident/Injury | Year |
|-----------------|------|
| | |
| | |
| | |
| | |

Vaccinations

Have you received your childhood vaccinations? Yes No

If yes, which did you receive?

- Polio Rubella Flu Vaccine Tetanus Measles Diphtheria
 Smallpox Mumps Hepatitis B Pertussis Other: _____

Have you received the vaccination for chicken pox? Yes No

Do you receive the yearly flu vaccination? Yes No Past

Have you received Gardasil®/HPV vaccination? Yes No

Have you received the 2009 H1N1 vaccination? Yes No

Have you received any vaccinations for travel? Yes No

If yes, which vaccinations _____

Allergies

Please list all known allergies to medications, supplements, food, environmental, vaccinations, etc:

Medications / Supplements

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

| Medications | Reason | Date began | Dose | Effective? (yes/no) |
|-------------|--------|------------|------|---------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Have you ever been treated with or used any of the following? (check all that apply)

- Antibiotics more than 2 weeks Antibiotics more than 2 times/year Antacids
 Antihistamines Blood thinners Diabetes medications
 Diuretics Hormonal therapy Laxatives/stool softener
 Sleeping pills Steroids Stimulants Thyroid medication

| Supplements | Reason | Date began | Dose | Effective? (yes/no) |
|-------------|--------|------------|------|------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Where do you purchase your supplements?

- Health food store Supplement store Club/Grocery store Internet Other _____

Family History

| Relative | Age if living | Age if deceased | Relative | Age if living | Age if deceased |
|----------|---------------|-----------------|----------------------|---------------|-----------------|
| Mother | | | Maternal Grandmother | | |
| Father | | | Maternal Grandfather | | |
| Siblings | | | Paternal Grandmother | | |
| | | | Paternal Grandfather | | |

Have your relative(s) ever had any of the following? *M = mother's side OR F = Father's side*

| Condition | M side | F side | Which Family Member(s) / Date |
|----------------------|--------|--------|-------------------------------|
| Alcoholism | | | |
| Allergies | | | |
| Alzheimer's | | | |
| Anemia | | | |
| Asthma | | | |
| Arthritis | | | |
| Bleeding disorders | | | |
| Cancer () | | | |
| Cancer () | | | |
| Celiac | | | |
| Crohns | | | |
| Depression | | | |
| Diabetes Type 1 | | | |
| Diabetes Type 2 | | | |
| Down's Syndrome | | | |
| Eczema | | | |
| Epilepsy | | | |
| Gall Bladder Disease | | | |
| Genetic Disorder | | | |
| Gout | | | |
| Heart Disease | | | |

| Condition | M side | F side | Which Family Member(s) / Date |
|----------------------|--------|--------|-------------------------------|
| Hemorrhoids | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Lupus | | | |
| Mental Illness | | | |
| Migraine Headaches | | | |
| Obesity | | | |
| Osteoporosis | | | |
| Stroke before age 50 | | | |
| Stroke after age 50 | | | |
| Thyroid (hypo/hyper) | | | |
| Other _____ | | | |
| Other _____ | | | |
| Other _____ | | | |
| Other _____ | | | |

Lifestyle

Relationship: Single Married Partnership Separated Divorced Widowed If Married/Partnership how long have you been together? _____

Live with: Spouse Partner Parents Children Friends Alone

Are you sexually active? Yes No If yes, with (check one): Male Female Both

Do you or your partner(s) use contraception? Yes No If so, what type(s)? _____

Are you pregnant? Yes No

Trying to get pregnant? Yes No If yes, for how long? _____

Do you have children? Yes No

How many? _____

Names and ages of your children? _____

Personal

What is your height? _____

| | Current | Last year | 5 years ago | Ideal |
|---------------|---------|-----------|-------------|-------|
| Weight in lbs | | | | |

Have you ever been a smoker? No Yes Yes, in past
 If yes, how many packs per day? _____ How long have you smoked? _____

Are you exposed to secondhand smoke? Yes No If yes, from where? _____

How often do you drink alcohol and how much at one time? _____

Do you use recreational drugs? Yes No How often? _____

How often do you exercise? _____ What kind of exercise do you do? _____

How much time to you spend outdoors per week? _____

What do you do to relax? _____

Describe your supportive network _____

Do you have a spiritual routine / practice? _____

What behaviors or habits do you engage in regularly to support your health? _____

What behaviors or habits do you engage in regularly that are destructive to your health? _____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health?

What is your occupation? _____

Do you like your job? Yes No

How many hours a week do you work? _____

To what extent are you open to changes in lifestyle to address your health concerns?

I am willing to consider changes I am willing to make some changes I will do whatever it takes

How many hours a night do you sleep? _____

What time do you go to bed? _____ What time do you rise in the morning? _____

Do you wake refreshed? Yes No

Do you have trouble falling asleep? Yes No If yes, what keeps you up? _____

Do you have trouble staying asleep? Yes No If yes, how many times a night do you wake up and is there a consistent time that you wake up throughout the night? _____

Diet

How many meals do you eat daily? _____

How much water do you drink daily? _____ What type of water do you drink? _____

How many sodas, coffees or teas with caffeine do you drink per week? _____

How many times per week do you eat dairy products? _____

How many times per week do you eat red meat? _____

How many times per week do you eat fish? _____

How many times per day do you eat fruit? _____

How many times per day do you eat vegetables? _____

Are there organic foods in your diet? Yes No

How often do you eat out? _____ /week

What foods do you crave? _____

Do you have dietary restrictions? Yes No

If yes, describe _____

Are you satisfied with your current diet? Yes No

If no, describe _____

Environmental Exposure

| | |
|---|--|
| Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home, at work or when traveling? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you sensitive to perfume, gasoline or other vapors? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever lived near a refinery or high pollution area? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever lived in a home more than 50 years old? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have mercury dental fillings? How many? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you had any dental root canal procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any surgical implants? (Medical or Cosmetic) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you live near power lines? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Review of Systems

Y = Yes for present symptoms or have had in past 3 months

P = Past symptoms. It is possible to check both "Y" and "P".

| General | |
|----------------|---|
| Chills | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Fever | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Fatigue | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Frequent Colds | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Night Sweats | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Weight Loss | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Skin | |
|-------------------|---|
| Acne | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Bruise easily | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Eczema | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Itching | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Lumps | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Mole color change | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Rashes | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Neurological | |
|---------------------|---|
| Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Loss of balance | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Loss of memory | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Muscle weakness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Numbness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Paralysis | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Tingling | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Vertigo / Dizziness | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Head | |
|-------------|---|
| Headaches | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Injury | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Migraines | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Eyes / Ears / Nose / Throat | |
|------------------------------------|---|
| Cataracts | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Dryness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Eye pain | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Glasses /Contacts | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Tearing | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Vision problems | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Ear discharge | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Ear pain | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Impaired hearing | <input type="checkbox"/> Y <input type="checkbox"/> P |
| ringing | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Hay fever | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Nosebleeds | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Post nasal drip | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Sinus problems | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Stiffness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Canker sores | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Frequent sore throat | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Goiter | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Gum problems | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Hoarseness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Jaw clicking /pain | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Lumps | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Neck pain /Stiffness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Sore tongue | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Swollen glands | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Teeth problems | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Respiratory | |
|---------------------|---|
| Asthma | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Cough | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Chronic cough | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Difficult breathing | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Emphysema | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Pain on breathing | <input type="checkbox"/> Y <input type="checkbox"/> P |

| | |
|---------------------|---|
| Positive TB test | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Shortness of breath | <input type="checkbox"/> Y <input type="checkbox"/> P |
| At night | <input type="checkbox"/> Y <input type="checkbox"/> P |
| On exertion | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Lying down | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Spitting up blood | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Wheezing | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Cardiovascular | |
|-----------------------|---|
| Anemia | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Blood clots | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Chest pain | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Cold hands | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Cold feet | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Heart disease | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Hemorrhoids | <input type="checkbox"/> Y <input type="checkbox"/> P |
| High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Low blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Leg cramps | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Murmur | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Palpitations | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Poor circulation | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Swelling of feet | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Varicose vein | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Gastrointestinal | |
|-------------------------|---|
| Belching / Gas | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Bloating | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Change in thirst | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Constipation | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Diarrhea | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Heartburn | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Itching around rectum | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Jaundice | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Nausea | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Trouble swallowing | <input type="checkbox"/> Y <input type="checkbox"/> P |

Patient Name _____ DOB _____

| | |
|---|---|
| Ulcer | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Undigested food in stool | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Vomiting | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Gallbladder Disease | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Liver Disease | <input type="checkbox"/> Y <input type="checkbox"/> P |
| How many bowel movements per day? _____ | |
| Is this a change? <input type="checkbox"/> Y <input type="checkbox"/> N | |
| Have you ever traveled to a third world country? If so, for how long? _____ | |

| Endocrine | |
|--------------------------------|---|
| Do you awake feeling rested? | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Generally feel cold | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Generally feel hot | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Low blood sugar | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Mental sluggishness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Recently lost or gained weight | <input type="checkbox"/> Y <input type="checkbox"/> P |
| 25 pounds change in weight | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Sluggish after eating | <input type="checkbox"/> Y <input type="checkbox"/> P |

Rate your **energy** level between 1 and 10 (1=extreme fatigue, 10=most energetic) _____

Rate your **stress** level between 1 and 10 (1 = less stress, 10 = extremely stressed) _____

At what time of the day is your energy the best? _____
the worst? _____

| Musculoskeletal | |
|-----------------|---|
| Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Broken bones | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Joint pain | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Joint stiffness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Muscle cramps | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Muscle spasms | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Sciatica | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Weakness | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Mental / Emotional | |
|---|---|
| Abuse | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Anxiety / nervousness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Depression | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Mental illness | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Mood swings | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Panic attacks | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Phobias | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Prolonged sadness or grief | <input type="checkbox"/> Y <input type="checkbox"/> P |
| What was the most stressful event in your life? _____ _____ | |
| It is still affecting you? <input type="checkbox"/> Y <input type="checkbox"/> N | |

| Immune | |
|---|---|
| Cold sores | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Chronic infections | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Frequent antibiotics | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Frequent colds/ flus | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Frequent sore throat | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Mononucleosis | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Shingles | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Slow wound healing | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Swollen glands or lymph nodes | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Has there ever been an event or sickness that you have never fully recovered from? <input type="checkbox"/> Y <input type="checkbox"/> N Explain. _____ | |

| Urinary | |
|-------------------------|---|
| Awaken to urinate | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Frequent infections | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Increased frequency | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Inability to hold urine | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Kidney stones | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Pain on urination | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Strain to urinate | <input type="checkbox"/> Y <input type="checkbox"/> P |

| Male Reproductive Health | | | | | |
|--------------------------|---|---------------------|---|-----------------------------------|---|
| Hernia | <input type="checkbox"/> Y <input type="checkbox"/> P | Testicular pain | <input type="checkbox"/> Y <input type="checkbox"/> P | Low sex drive | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Discharge or sores | <input type="checkbox"/> Y <input type="checkbox"/> P | Sexual difficulties | <input type="checkbox"/> Y <input type="checkbox"/> P | Prostate conditions | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Testicular mass | <input type="checkbox"/> Y <input type="checkbox"/> P | Impotence | <input type="checkbox"/> Y <input type="checkbox"/> P | Date of last prostate exam? _____ | |
| STD | <input type="checkbox"/> Y <input type="checkbox"/> P | | | | |

Trouble with urination (frequency, hesitancy, pain, dribbling)? _____

Female only

| Female Reproductive Health | | | | | |
|----------------------------|---|-------------------------|---|-------------------------|---|
| Discharge | <input type="checkbox"/> Y <input type="checkbox"/> P | Sexual difficulties | <input type="checkbox"/> Y <input type="checkbox"/> P | Pain during intercourse | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Itching | <input type="checkbox"/> Y <input type="checkbox"/> P | Sores, growths, lumps | <input type="checkbox"/> Y <input type="checkbox"/> P | Pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N # of _____ |
| Vaginal dryness | <input type="checkbox"/> Y <input type="checkbox"/> P | Odor | <input type="checkbox"/> Y <input type="checkbox"/> P | Abortions | <input type="checkbox"/> Y <input type="checkbox"/> N # of _____ |
| Use tampons | <input type="checkbox"/> Y <input type="checkbox"/> P | Abdominal pain midcycle | <input type="checkbox"/> Y <input type="checkbox"/> P | Miscarriages | <input type="checkbox"/> Y <input type="checkbox"/> N # of _____ |
| STD | <input type="checkbox"/> Y <input type="checkbox"/> P | Low sex drive | <input type="checkbox"/> Y <input type="checkbox"/> P | Tubal Pregnancy | <input type="checkbox"/> Y <input type="checkbox"/> N # of _____ |

Date of last pap smear? _____ History of abnormal pap? _____

How frequent do you have a gynecologic / pelvic exam/pap smears? _____

Any cervical cancer history? _____ If yes, when: _____

Any ovarian cancer history? _____ If yes, when: _____

If menopausal or perimenopausal: List symptoms and concerns: _____

| Female Breast Health | | | | | |
|----------------------|---|--------------------|---|---------------------|---|
| Breast lump | <input type="checkbox"/> Y <input type="checkbox"/> P | Dry skin on nipple | <input type="checkbox"/> Y <input type="checkbox"/> P | Fibrocystic breasts | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Nipple discharge | <input type="checkbox"/> Y <input type="checkbox"/> P | Puckering of skin | <input type="checkbox"/> Y <input type="checkbox"/> P | Tenderness | <input type="checkbox"/> Y <input type="checkbox"/> P |

When was your last breast exam? _____

Do you perform monthly self breast exams? Yes No

Do you have regular mammograms? Yes No

Any personal history of breast cancer? _____

| Premenstrual / Menstrual symptoms | | | | | |
|-----------------------------------|---|-------------------|---|-----------------|---|
| Bleeding between periods | <input type="checkbox"/> Y <input type="checkbox"/> P | Breast tenderness | <input type="checkbox"/> Y <input type="checkbox"/> P | Clotting | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Cravings | <input type="checkbox"/> Y <input type="checkbox"/> P | Headaches | <input type="checkbox"/> Y <input type="checkbox"/> P | Heavy flow | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Light flow | <input type="checkbox"/> Y <input type="checkbox"/> P | Low back aches | <input type="checkbox"/> Y <input type="checkbox"/> P | Mood swings | <input type="checkbox"/> Y <input type="checkbox"/> P |
| Missed periods | <input type="checkbox"/> Y <input type="checkbox"/> P | Pain/cramping | <input type="checkbox"/> Y <input type="checkbox"/> P | Water retention | <input type="checkbox"/> Y <input type="checkbox"/> P |

Onset of first menses was age _____

Periods generally last _____ days and occur every _____ days

Date of last period _____

Bleeding is Heavy Moderate Light

Number of pads/tampons used on heaviest day? _____

Thank you for taking the time to fill out this form. I look forward to working you.