



FEMALE HEALTH STATUS INTERVIEW

version 11-17-2007

Patient Note: This is a confidential record of your medical history. It will not be released except when you have authorized us to do so.

Successful health care and preventive medicine are only possible when the doctor has a thorough understanding of your health – physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark. Thank you.

Last Name: _____ First Name: _____ MI: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: M F

Your Occupation: _____ Number of hours per week: _____

Single Married Separated Divorced Widowed Partnership

Name of Spouse/Significant Other: _____

Are you receiving health care anywhere else? Yes / No

If yes where and from whom? _____

Chief Complaints: List your health concerns in order of their importance to you. Please include dates of onset.

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Your Occupation: _____ Number of hours per week: _____

Are you receiving health care anywhere else? Yes / No

If yes where and from whom? _____

Allergies

To any drugs? _____

To any foods? _____

To any environmental pollens/grasses? _____

Other? _____

Surgeries: List the type and year of any surgeries:

Hospitalizations: List any other hospitalizations and the reason:

List all the **medications** that you are currently taking, including dosage

Be sure to include things such as: Laxatives, Cortisone, Tranquilizers, Pain Reliever, Appetite suppressants, Thyroid medications, Antacids, Antibiotics, Sleeping pills, Birth Control Pills, water pills, hormone replacement, blood pressure medications and any other prescription medications:

List all **vitamins, minerals, herbs, homeopathic remedies and nutritional supplements** you are currently taking:

Personal Habits:

Do you eat three meals per day?	YES	NO	Do you consume alcohol?	YES	NO
How many hours of sleep each night? _____			Beer	Wine	Spirits
Do you wake feeling rested?	YES	NO	Number of drinks per day/week/month _____		
Do you spend time outside?	YES	NO	Do you smoke?	YES	NO
Do you have a supportive relationship?	YES	NO	Current	Past	
Do you take vacations?	YES	NO	Yr started _____	Yr stopped _____	
Have you had any major traumas?	YES	NO	Recreational drug use?	YES	NO
Do you have a history of abuse? (physical, emotional or sexual)	YES	NO	amphetamines	barbituates	PAST
Do you drink coffee?	YES	NO	heroin	cocaine	marijuana
Do you drink black tea?	YES	NO	other _____		
Do you drink sodas or energy drinks?	YES	NO	Religious or spiritual practice?	YES	NO
Do you consume sugar?	YES	NO	Do you enjoy your job?	YES	NO
			Do you watch TV? YES	NO	hrs per week _____
			Do you read? ? YES	NO	hrs per week _____

Typical Daily Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much/often do you consume of the following?

<input type="checkbox"/> soda or carbonated beverages	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> white flour products	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> fried foods	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> raw foods	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> refined sugar	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> red meat or pork	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> tap water	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> fresh vegetables	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> fresh fruit	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> pure water (eg. bottled)	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> cook with shortening or oils other than coconut oil	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> margarine	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> green leafy vegetables (spinach, salad, etc)	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> sweets/deserts	NEVER	RARELY	SOMETIMES	FREQUENT
<input type="checkbox"/> candy	NEVER	RARELY	SOMETIMES	FREQUENT

Current Metabolic Status: Please indicate your present state for each of the following items

Sleep. usual bedtime, hours slept, problems with falling asleep or waking up after your fall asleep. dreams and or nightmares

Energy Level when waking up, throughout the day.

Bowel Movements. frequency (number per day), quality of stools (small and hard, loose, etc.)

Urination. approximate number of times per day, waking up at night to urinate, pain or other symptoms during urination, etc.

Perspiration. do you perspire excessively during the day or at night. do you NOT perspire when it would be appropriate to do so (for example, during exercise)

Exercise

How often do you exercise and what type of exercise?

Do you experience any symptoms during exercise (pain in any particular place in your body, shortness of breath, extreme fatigue beyond what is normal for the activity, heart palpitations, dizziness, abnormally high or low perspiration, etc.)?

If you know your blood type, please tell us: _____

Weight _____ Weight 1 year ago _____ Maximum Weight _____ when? _____

What do you think should be your desired weight _____ Height _____

Personal Medical History: Please circle any of the following conditions/symptoms you have had, **Yes**-I have this now; **Never**-I've never had it; **Past**-I've had it in the past but not now.

Head

Headaches?	YES	NEVER	PAST	Head injury or trauma?	YES	NEVER	PAST
Migraines?	YES	NEVER	PAST	Concussion?	YES	NEVER	PAST
Lightheadedness?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST	Jaw/TMJ problems?	YES	NEVER	PAST
Bell's Palsy?	YES	NEVER	PAST	Other? _____			

Eyes

Spots in Eyes?	YES	NEVER	PAST	Cataracts?	YES	NEVER	PAST
Impaired vision?	YES	NEVER	PAST	Glasses/Contacts?	YES	NEVER	PAST
Blurriness?	YES	NEVER	PAST	Tearing or dryness?	YES	NEVER	PAST
Color blindness?	YES	NEVER	PAST	Glaucoma?	YES	NEVER	PAST
Double Vision?	YES	NEVER	PAST	Night Blindness?	YES	NEVER	PAST
Eye Pain?	YES	NEVER	PAST	Circles under eyes?	YES	NEVER	PAST
Swollen Eyes?	YES	NEVER	PAST	Other? _____			
Eyestrain?	YES	NEVER	PAST				

Ears

Impaired hearing?	YES	NEVER	PAST	Ringling in ears?	YES	NEVER	PAST
Deafness?	YES	NEVER	PAST	Excessive ear wax?	YES	NEVER	PAST
Earaches?	YES	NEVER	PAST	Frequent ear infections?	YES	NEVER	PAST
Itching of ears?	YES	NEVER	PAST	Other? _____			

Nose & Sinuses

Frequent Colds?	YES	NEVER	PAST	Nose Bleeds?	YES	NEVER	PAST
Stiffness?	YES	NEVER	PAST	Sinus Problems?	YES	NEVER	PAST
Post Nasal Drips?	YES	NEVER	PAST	Hayfever?	YES	NEVER	PAST
Loss of Smell?	YES	NEVER	PAST	Allergies?	YES	NEVER	PAST
Bell's Palsy?	YES	NEVER	PAST	Polyps?	YES	NEVER	PAST
				Other? _____			

Mouth & Throat

Frequent sore throat? YES NEVER PAST
 Sores in mouth? YES NEVER PAST
 Hoarseness? YES NEVER PAST
 Difficulty Swallowing? YES NEVER PAST
 Loss of Taste? YES NEVER PAST
 Teeth Grinding? YES NEVER PAST
 Sore Lips? YES NEVER PAST
 Enlarged lymph nodes YES NEVER PAST

Sore Tongue? YES NEVER PAST
 Gum problems? YES NEVER PAST
 Dental Problems? YES NEVER PAST
 Difficulty Speaking? YES NEVER PAST
 Dental Cavities? YES NEVER PAST
 Jaw Clicks? YES NEVER PAST
 Copious Saliva? YES NEVER PAST
 Dry Mouth? YES NEVER PAST
 Other? _____

Respiratory

Coughing? YES NEVER PAST
 Spitting up blood? YES NEVER PAST
 Wheezing? YES NEVER PAST
 Difficulty breathing? YES NEVER PAST
 Pain with breathing? YES NEVER PAST
 Shortness of breath? YES NEVER PAST
 - while lying down? YES NEVER PAST
 - at night? YES NEVER PAST

Sputum? YES NEVER PAST
 Bronchitis? YES NEVER PAST
 Pleurisy? YES NEVER PAST
 Emphysema? YES NEVER PAST
 Pneumonia? YES NEVER PAST
 Asthma? YES NEVER PAST
 Positive TB Test? YES NEVER PAST
 Other? _____

Cardiovascular

Heart disease? YES NEVER PAST
 High/Low blood pressure? YES NEVER PAST
 Blood Clots? YES NEVER PAST
 Phlebitis? YES NEVER PAST
 Rheumatic Fever? YES NEVER PAST
 Swelling in ankles? YES NEVER PAST
 Bleeding/clotting disorder? YES NEVER PAST
 High cholesterol? YES NEVER PAST
 Atherosclerosis? YES NEVER PAST

Angina? YES NEVER PAST
 Heart murmurs? YES NEVER PAST
 Fainting? YES NEVER PAST
 Palpitations? YES NEVER PAST
 Heart Flutters? YES NEVER PAST
 Chest Pain? YES NEVER PAST
 Stroke? YES NEVER PAST
 Heart attack? YES NEVER PAST
 Other? _____

Circulation

Cold hands/feet? YES NEVER PAST
 Deep leg pain? YES NEVER PAST
 Easy bleeding/bruising? YES NEVER PAST

Varicose veins? YES NEVER PAST
 Anemia? YES NEVER PAST
 Thrombophlebitis? YES NEVER PAST
 Other? _____

Urinary

Pain during urination? YES NEVER PAST
 Frequency at night? YES NEVER PAST
 Bladder infections? YES NEVER PAST
 Unable to urinate? YES NEVER PAST

Increased frequency? YES NEVER PAST
 Unable to hold urine? YES NEVER PAST
 Kidney stones? YES NEVER PAST
 Blood in urine? YES NEVER PAST
 Other? _____

Gastrointestinal

Trouble swallowing?	YES	NEVER	PAST	Liver disease?	YES	NEVER	PAST
Jaundice?	YES	NEVER	PAST	Hepatitis?	YES	NEVER	PAST
Nausea?	YES	NEVER	PAST	Heartburn?	YES	NEVER	PAST
Vomiting blood?	YES	NEVER	PAST	Acid Reflux?	YES	NEVER	PAST
Blood in stool?	YES	NEVER	PAST	Change in appetite?	YES	NEVER	PAST
Abdominal pain/cramps?	YES	NEVER	PAST	Vomiting?	YES	NEVER	PAST
Belching or passing gas?	YES	NEVER	PAST	Diarrhea?	YES	NEVER	PAST
Gallbladder disease?	YES	NEVER	PAST	Constipation?	YES	NEVER	PAST
Ulcers?	YES	NEVER	PAST	Bloating?	YES	NEVER	PAST
Stomach pain?	YES	NEVER	PAST	Hemorrhoids?	YES	NEVER	PAST
Black Stools?	YES	NEVER	PAST	Change in thirst?	YES	NEVER	PAST
Diverticulitis/losis?	YES	NEVER	PAST	Colitis?	YES	NEVER	PAST
Crohn's disease?	YES	NEVER	PAST	Hiatal Hernia?	YES	NEVER	PAST
Irritable Bowel Syndrome?	YES	NEVER	PAST	Other? _____			

Skin

Rashes?	YES	NEVER	PAST	Itching?	YES	NEVER	PAST
Hives?	YES	NEVER	PAST	Dryness?	YES	NEVER	PAST
Acne, boils?	YES	NEVER	PAST	Perpetual hair loss?	YES	NEVER	PAST
Color changes?	YES	NEVER	PAST	Night sweats?	YES	NEVER	PAST
Lumps?	YES	NEVER	PAST	Sores?	YES	NEVER	PAST
Ulceration?	YES	NEVER	PAST	Infections?	YES	NEVER	PAST
Shingles?	YES	NEVER	PAST	change in hair/nails?	YES	NEVER	PAST
Eczema?	YES	NEVER	PAST	Other? _____			
Psoriasis?	YES	NEVER	PAST				

Neck

Pain or stiffness?	YES	NEVER	PAST	Lumps?	YES	NEVER	PAST
Swollen Glands?	YES	NEVER	PAST	Herniated disk?	YES	NEVER	PAST
Pinched nerve?	YES	NEVER	PAST	Other? _____			

Musculoskeletal

Joint pain or stiffness?	YES	NEVER	PAST	Osteopenia?	YES	NEVER	PAST
Muscle spasms?	YES	NEVER	PAST	Broken Bones?	YES	NEVER	PAST
Muscle weakness?	YES	NEVER	PAST	Back Pain?	YES	NEVER	PAST
Arthritis?	YES	NEVER	PAST	Herniated disk?	YES	NEVER	PAST
Bursitis?	YES	NEVER	PAST	Back surgery?	YES	NEVER	PAST
Osteoporosis?	YES	NEVER	PAST	Other? _____			

Neurological

Seizures?	YES	NEVER	PAST	Paralysis?	YES	NEVER	PAST
Muscle weakness?	YES	NEVER	PAST	Numbness or tingling?	YES	NEVER	PAST
Loss of memory?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Vertigo?	YES	NEVER	PAST	Lightheaded?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST	Poor concentration?	YES	NEVER	PAST
Trembling hands/feet?	YES	NEVER	PAST	Slurred Speech?	YES	NEVER	PAST
Mood swings?	YES	NEVER	PAST	Neuralgia?	YES	NEVER	PAST
Epilepsy?	YES	NEVER	PAST	Loss of Coordination?	YES	NEVER	PAST
Easily stressed?	YES	NEVER	PAST	Other? _____			

Mental / Emotional

Excess Stress?	YES	NEVER	PAST	Suicidal thoughts?	YES	NEVER	PAST
Anxiety?	YES	NEVER	PAST	Treated for emotions?	YES	NEVER	PAST
Panic Attacks?	YES	NEVER	PAST	Nervousness?	YES	NEVER	PAST
Depression?	YES	NEVER	PAST	Seasonal depression?	YES	NEVER	PAST
Mood swings?	YES	NEVER	PAST	Other? _____			
Memory loss?	YES	NEVER	PAST				

Endocrine

Hypothyroid?	YES	NEVER	PAST	Heat or cold intolerance?	YES	NEVER	PAST
Hyperthyroid?	YES	NEVER	PAST	Diabetes?	YES	NEVER	PAST
Hypoglycemia?	YES	NEVER	PAST	Excessive hunger?	YES	NEVER	PAST
Excessive thirst?	YES	NEVER	PAST	Seasonal depression?	YES	NEVER	PAST
Unexplained weight loss?	YES	NEVER	PAST	Easy weight gain?	YES	NEVER	PAST
Poor appetite?	YES	NEVER	PAST	Pituitary disorder?	YES	NEVER	PAST
Fatigue?	YES	NEVER	PAST	Adrenal problem?	YES	NEVER	PAST
Hormonal problems?	YES	NEVER	PAST	Other? _____			

Immune

Slow wound healing?	YES	NEVER	PAST	Reaction to vaccinations?	YES	NEVER	PAST
Chronic fatigue synd.?	YES	NEVER	PAST	Chronic infections?	YES	NEVER	PAST
Chronic swollen glands?	YES	NEVER	PAST	Cancer?	YES	NEVER	PAST
				Other? _____			

Infectious Illnesses

Scarlet Fever?	YES	NEVER	PAST	Mumps?	YES	NEVER	PAST
Diphtheria?	YES	NEVER	PAST	Measles?	YES	NEVER	PAST
Rheumatic Fever?	YES	NEVER	PAST	Polio?	YES	NEVER	PAST
Chicken Pox?	YES	NEVER	PAST	Meningitis?	YES	NEVER	PAST
German Measles?	YES	NEVER	PAST	Epstein-Barr?	YES	NEVER	PAST
				Other? _____			

Female Reproductive History:**Menstruation**

Your age when you had your first menstrual period? _____

Are you past menopause? Y N

What was the date of the start of your most recent menstrual period? _____

How long do your periods last? _____ Are your cycles regular? _____

How long is your cycle (from the start of one period to the start of the next)? _____

Do you use pads or tampons? _____ How many on heaviest day? _____

Do you experience cramps, pain or other symptoms during your period? _____

Pre-Menstrual Symptoms

Do you experience any of the following prior to your menstrual period?

___ Breast Tenderness ___ Bloating ___ Skin Problems

___ Mood Changes _____ ___ Headache

___ Cramping ___ Diarrhea ___ Appetite Changes _____

___ Low Back Pain ___ Constipation ___ Discharge (breast, vaginal) _____

Do any of the above symptoms improve with the start of your flow? _____

Gynecological Conditions

Have you every had recurring bladder or vaginal infections? _____

Have you ever had gynecological or breast surgery (including breast augmentation)? _____

Current problems or past history of herpes, venereal warts, gonorrhea, syphilis, Chlamydia, HIV/AIDS or other STD? _____

Date of your last PAP? _____ Ever had an abnormal PAP? _____

Date of last mammogram? _____

Have you ever had any of the following conditions?

breasts: ___ discharge ___ tenderness ___ swelling ___ lumps ___ fibrocystic breasts

___ polycystic ovary disease ___ uterine fibroids ___ cervical cancer

Sexual History

Are you currently sexually active?_____ Do you have multiple partners? _____

If yes, with men, women or both? _____ Do you experience pain or discomfort during sex?_____

Birth Control

___ none	past present	___ hysterectomy
___ IUD	past present	___ Tubal ligation
___ Diaphragm	past present	___ oral contraceptive _____
___ condoms	past present	___ patch / implant _____
___ partner vasectomy	past present	___ other _____

Pregnancy History

Times pregnant _____ Live births _____ miscarriages _____ abortions _____ premature births_____

Pg #	DOB	birth wt	gender	length of preg	delivery type	breast fed?	complications or problems?
1	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____	_____

Your Own Childhood History: To the best of your memory, please provide the following information about YOUR childhood

Age of your mother when you were born: _____

Number of her previous pregnancies: _____

Indicate any medical problems your mother had while pregnant with you?

Did your mother take any medications during pregnancy:

Did she use Alcohol or Tobacco while pregnant with you or while nursing? Y N

Does your mother have any allergies: _____

Were you breastfed as a child and if so, how long?

What vaccinations did you receive as a child and at what ages?

MMR: _____ Hepatitis B _____
 Polio _____ Tetanus booster _____
 Hepatitis A _____ Varicella _____
 DPT: _____ Other _____
 Hib _____

Did your parents note any adverse reactions to vaccinations or illnesses around the time you received them?

During each of the following age periods, 1) where did you live, 2) what illnesses did you have?

- birth to 2 years

- 2 years to 5 years

- 5 years to puberty

- puberty through roughly age 20

Family Medical History:

	Father	Mother	Brothers			Sisters			Other Relatives		
			1	2	3	1	2	3			
Age (if living)											
Cancer											
Diabetes											
Heart trouble											
High Blood Pressure											
Stroke											
Epilepsy											
Mental Disorders											
Asthma											
Allergies											
Other Conditions											
Age at death											
Cause of Death											

Hobbies & Interests

Hobbies & Interests: _____

What do you enjoy doing the most? _____

How often do you do the above activities? _____

Your Opinions About Your Health

How does your condition affect you? _____

What do you think is happening; why do you think you have this condition? _____

What do you feel needs to happen for you to get better? _____

Is there any additional information you would like to add? _____

How much change are you willing to make at this time for improving your health?

circle one: MINIMAL SOME COMPLETE

FORM COMPLETE!

Welcome to South Bay Total Health