



Female Health History Form

Name \_\_\_\_\_ DOB \_\_\_\_\_

How did you hear about Integrative Family Medicine, LLC? \_\_\_\_\_

When was the last time you saw a Doctor?	When was the last time you felt well?
--	---------------------------------------

What is the reason for your appointment? (list in order of importance)	Symptoms/Explanation ↓:
1.	
2	
3	

1. Diagnoses Check the appropriate box for conditions you've been treated for: C = Current, P = Past

C	P	C = Current, P = Past	C	P	C = Current, P = Past	C	P	C = Current, P = Past
		High Blood Pressure			Bipolar			Cystitis
		High Cholesterol			Anxiety disorder			Recurrent Urinary Tract Infections
		Heart Attack/Angina			Mono			Sexually Transmitted Diseases
		Stroke			Lyme Disease			Hepatitis B or C
		Diabetes			Chronic Fatigue Syndrome			Liver Disease
		Asthma			Fibromyalgia			Gallbladder disease
		Eczema			Multiple Chemical Sensitivity			HIV/AIDS
		Celiac Disease			Adrenal Fatigue			Pancreatic Cancer
		Other Food Allergies			Hypothyroidism			Irritable Bowel Syndrome
		Parkinson's Disease			Hyperthyroidism			Inflammatory Bowel (Crohns, UC)
		Breast Cancer			Lupus			Constipation
		Fibroids			Rheumatoid Arthritis			Diverticulitis
		Ovarian Cancer			Low Back Pain			Kidney Stones
		Cancer of the cervix			Osteoarthritis			Heart Murmur
		Uterine Cancer			Osteopenia			Anemia
		Endometriosis			Osteoporosis			Aortic Aneurysms
		Alcoholism			Multiple Sclerosis			Acid Reflux
		Drug Abuse			Epilepsy/Seizures			Seasonal Allergies
		Depression			Sinusitis			Tuberculosis
		Schizophrenia			Bronchitis			Amalgams (Silver fillings)
		ADD/ADHD			Migraines			Other Skin Problem

Other: \_\_\_\_\_



#### 4. Allergies

Medication	Reaction

#### 5. Timeline Please give the dates of and describe any major illnesses, injuries, hospitalizations and all surgeries

Your birth (Normal Vaginal delivery, etc):

Breastfed (for how long)?:

Problems as a child?

How many times have you been treated with antibiotics?

## 6. Ob/Gyn History (STD = Sexually Transmitted Disease)

How many times have you been pregnant?		How old were you when you first started having sex?	
How many times have you delivered?		How many partners have you had?	
→ Vaginally?    Cesarean?		Are you currently sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many living children to you have?		Do you have sex with	<input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both
How many miscarriages?		What type of protection for STDs do you use?	
How many abortions?		Are you concerned about having an STD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you breastfeed your children, how long?		What type of contraception do you use?	
Age of menstruation		What type of contraception have you used in the past?	
Length of menses (Number of days of bleeding)			
Length of cycle (# of days between the 1st day of menses)		When was your last pap smear?	
Are your cycles irregular?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had an abnormal pap smear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are they particularly painful or discomforting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had a culposcopy (a procedure on your cervix for abnormal pap smears)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are they heavy?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you do self breast exams monthly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been on hormone replacement therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>First day of Last menstrual Period:</b>		How old was your mother when she went through menopause?	
Other:			

## 7. Preventative Medicine (fill in dates if applicable)

Screening	Date Completed	Results or Follow-Up Treatment
Mammogram		
Bone Density		
<input type="checkbox"/> Colonoscopy, <input type="checkbox"/> Flexible Sigmoidoscopy <input type="checkbox"/> Stool Cards		
Cholesterol		
EKG		
Stress Test		
Vision Screening		

## Please indicate what immunizations you have had and when (NL = Normal childhood vaccination)

DPT (diphtheria, pertussis, tetanus)		Tetanus booster; when?	
Hib (Haemophilus influenza B)		Flu Shot	
Hepatitis B		→ Do you get them yearly?	
Hepatitis A		Polio	
MMR (measles, mumps, rubella)		Smallpox	
Other:			
Adverse reactions:			

**8. Family History**    Adopted?    Yes    No   (If adopted, fill out any known information on biologic relatives)

Check all that apply. Under Grandparent and Aunt/Uncle, write M for Maternal relative, P for Paternal relative. Write "Half" if step brother or sister.	Mother	Father	Sibling	Grand-parent	Aunt/ Uncle
High Blood Pressure					
High Cholesterol					
Heart Attack (write in age they were when it occurred)					
Stroke (write in age they were when in occurred)					
Diabetes					
Asthma					
Celiac Disease					
Other Food Allergies					
Alzheimer's Disease					
Parkinson's Disease					
Breast Cancer					
Fibroids					
Ovarian Cancer					
Stomach Cancer					
Pancreatic Cancer					
Hypothyroidism					
Alcoholism					
Drug Abuse					
Depression					
Schizophrenia					
Bipolar					
Anxiety disorder					
Other:					

**9. Social History**

<b>Smoke:</b>	Have you ever smoked regularly?	What type (cigarettes, pipe, etc)	Amount (Packs per day)	Month/Year Started	Month/Year Quit
	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Are you exposed to passive smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>EtOH:</b>	How often do you drink alcohol?	What type of alcohol?			
	How many drinks?	How many ounces in a drink?			
Has anyone ever been concerned about your drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Drugs:</b>	Do you use other drugs or substances that could affect your health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	→ If yes, explain:				
<b>Diet</b>	Special Diet?				
1) How many caffeinated drinks a day?			2) What type of caffeinated drink?		
3) Do you use artificial sugars?			4) How often?		
5) How many glasses (8 oz) of water a day?			6) Other drinks		
7) How often do you eat out in a week?			8) How often do you have fast food?		
9) How often do you have processed or ready made food?			10) Do you skip meals?		

Write the number of servings a week you have of each of the following:

Food	Amount	Food	Amount
Milk (glasses)		Candy/Chocolate	
Cheese		Cakes/brownies/cookies, etc	
Ice Cream		Beef	
Yogurt		Chicken/turkey	
Brown Rice		Eggs	
Oatmeal		Pork	
Whole grain bread		Seafood (list types)	
Whole grain pasta		Beans	
Millet/Barley/Quinoa or other grain		Peas	
White bread		Lentils	
White pasta		Cooked Vegetables	
Bagels		Raw Vegetables	
Fruits (dried, canned, etc)		Nuts and seeds	
Raw Fruits		Soy products	

Typical Diet (as detailed as possible: amount, how cooked, already prepared, etc)

Breakfast

Lunch

Dinner

Snacks

Foods you crave

Aversions to foods:

<b>Lifestyle</b>	Your Occupation:	
Past occupations that might be significant:		
Name of Significant Other:		Their Occupation:
# of people in household:		Ages of Children:
Pets:		Working smoke detector in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Dwelling:		Age of Home:
Concern for wet basement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		Radon Detector or air flow system present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Concern for possible Exposure to toxic substances (work chemicals, DES, asbestos, Sick Bldg Syndrome. etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Explain toxic substances concerns:		
Frequent or Recent Travel:		
Spirituality:		
What are your regular spiritual practices (meditation, deep breathing, prayer)		
→ How many times per week do you do them?		→ For how many minutes?
What do you LOVE to do?		
Support System:		
Recent significant change in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		
Financial Hardship? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		
Special stresses in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:		
I am not happy with <input type="checkbox"/> Myself <input type="checkbox"/> My Health <input type="checkbox"/> My Work <input type="checkbox"/> My Life <input type="checkbox"/> My Partner		
Have you been in an abusive relationship? <input type="checkbox"/> Yes <input type="checkbox"/> No		Comments:
Does your partner ever hit, hurt or threaten you in any way? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you ever frightened of your partner? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Exercise</b>	Why do you exercise?	
Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No" skip questions with arrow)		→ How many times per week?
→ How many minutes per session?		→ On a scale of 1-10 (10 being the most) how vigorous is it?
What type of exercise?		
How many hours of TV do you watch a day?		
<b>Sleep</b>	If no problems with sleep, skip questions with arrow ( →)	
When do you go to bed?		When do you fall asleep?
→ How many times do you wake up?		→ How long to go back to sleep?
When do you wake up in the morning?		→ When do you wake up on the weekends?
→ Do you use an alarm clock?		→ Do you wake up refreshed (weekdays)?
→ Do you take naps?		→ Do you fall asleep without intending to?
→ you snore?		→ Do you use a noise maker?
→ Is the room very dark?		→ Is there a TV or computer in the room?

**10. Review of Systems** Write “1” for occasional symptoms, “2” for weekly, “3” for almost daily or daily. Leave blank if less than once a month or does not occur. For menstrual questions, mark X if regularly occurs

“Second wind” of energy at night		Feel wired/jittery after coffee	
Difficulty falling asleep		Clench or grind teeth	
Feel worse after exercising		Trouble calming down	
Chronic low back pain		Persistent headaches for no apparent reason	
Easily dizzy upon standing			
Arthritis or arthralgia (bone/joint pain)			
Crave salty foods			
Allergies/food intolerances/hives			
Shin splints and/or easily spraining ankles			
Perspire easily			
Afternoon headache			
Difficulty loosing weight		Fast pulse, even at rest	
Brain Fog		Easily flush	
Decreased volition		Feel hot all the time	
Sleepy throughout the day		Rarely gain weight despite large appetite	
Sensitive to cold		Nervous/Emotional	
Dry, brittle hair			
Hair loss			
Dry skin			
Chronic constipation			
Morning headaches			
Difficulty digesting greasy foods		Easily car sick/ motion sickness	
Stools appear greasy or shiny		Sensitive to chemicals	
Stools float		Pain between shoulder blades	
Stools are light or clay colored		Bitter taste in mouth after meals	
Nausea		Belching	
Itchy or peeling skin on feet		Flatulence	
Headache around eyes		Undigested foods in stool	
Hot flushes		Breast tenderness	
Night sweats		PMS	
Vaginal Dryness		Endometriosis	
Poor memory		Heavy periods	
Tearful		Fibrocystic breasts	
Hair loss		Heavy hips/abdomen	
Scanty menses		Water retention	
Low libido		Good mental acuity and physical stamina	
Weak muscles		Facial hair	
Low energy		Acne	
Joint aches and pains		Sore nipples	

PMS		Night Sweats	
History of miscarriages		Lightheaded/dizzy	
Irregular menses		Fatigued	
Heavy menses			
Clots with menses			
Breast tenderness			
Insomnia			
Migraines			
Fibroids			
Infertility			
Endometriosis			

Score each symptom you have CURRENTLY with a 1-5, 5 being the most symptomatic. Leave it blank if not experiencing.

General		Gastroenterology		Dermatology	
	Fever		Nausea		Rash
	Chills		Vomiting		Itching
	Night Sweats		Diarrhea		Dryness
	Fatigue		Constipation		Suspicious skin lesions
	Weakness		Change in bowel habits	<b>Neurology</b>	
	Just don't feel well		Abdominal pain		Paralysis
	Weight loss		Black, soft tar-like stools		Unusual sensations
	Sleep problems		Bloody stools		Seizures
<b>Eyes</b>			Gas/Bloating		Tremors
	Blurring of your vision		Indigestion/Heartburn		Vertigo / Dizziness
	Double vision		Difficulty swallowing		Temporary blindness
	Discharge of the eyes		Decreased Appetite		Frequent falls
	Vision loss or change	<b>Genitourinary</b>			Frequent headaches
	Eye pain		Vaginal discharge		Difficulty walking
	Eyes are sensitive to light		Leaking urine/Incontinent	<b>Psychiatric</b>	
<b>Ears, Nose, Throat</b>			Painful urination		Depression
	Earache		Blood in the urine		Anxiety
	Ear discharge		Frequent urination		Memory loss
	Tinnitus / Ringing in Ears		Missed periods		Suicide thoughts
	Decreased hearing		Heavy periods		Hallucinations
	Nasal congestion		Unusual vaginal bleeding		Paranoia
	Hoarseness		Pelvic pain		Phobia / Fear of things
<b>Cardiovascular</b>			Genital sores		Confusion
	Chest pains		Decreased libido	<b>Endocrinology</b>	
	Palpitations / Skipped beats	<b>Musculoskeletal</b>			Constantly Cold
	Syncope / Fainting		Back pain		Constantly Hot
	Difficult breathing on exertion		Joint pain		Constantly thirsty
	Difficult breathing laying down		Joint swelling		Constantly hungry
	Swelling in your legs or ankles		Muscle cramps		Weight Gain
<b>Respiratory</b>			Muscle weakness	<b>Hematology</b>	
	Cough		Stiffness		Unusual bruising
	Difficult breathing at rest		Arthritis		Unusual bleeding
	Excessive sputum / phlegm		Sciatica / Pain down the legs		Enlarged lymph nodes
	Wheezing		Restless legs	<b>Immune</b>	
	Runny nose or post nasal drip		Leg pain at night		Hives
<b>Other</b>					Food sensitivity
					Frequent Colds (Respiratory Illness)
					Environmental Allergies (pollen, etc)

**Digestion** Score each symptom you have CURRENTLY with a 1-5, 5 being the most symptomatic. Leave it blank if not experiencing.

Cannot take vitamins because of Stomach upset		Prefer to skip breakfast	
Sense of fullness after meals		Tired after meals	
Sweat smells strongly		Diarrhea after eating	
Bad breath		Chipping, peeling fingernails	
Food allergies/sensitivities		Foods can't live without	
Environmental allergies		Crave rice, bread, noodles	
Bloating 1-2 hours after eating		Sinus congestion	
Hives		Alternating diarrhea and Constipation	
Itchiness around your anus		Circles under eyes	
Mucus on stool		History of candida or other yeast, fungus infection	
Blood on stool		Yeast symptoms increase with sugars, alcohol, vinegar	
Bad breath		Symptoms worse in musty/moldy places	
Strong body odor		Need to strain	
Crave greasy foods		Headaches easily when in hot sun	
Dry, flaky skin		Sunburn more than expected	
Muscles easily fatigued		Tension headaches at base of skull	

**Other Notes:**

**To the best of my knowledge, this document is an accurate statement of my health**

**Date** \_\_\_\_\_