General Health History Questionnaire

(To be completed by patient)

Name: _____ Date: _____
Date of Birth: _____ Age: _____
Sex: M / F (circle one) Weight: _____ Height: _____
Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____
Work #: _____ Email: _____
In Case Of Emergency name & #: _____

Chief Complaint(s): _____
_____
_____
_____

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

- ☐ Antacids, Zantac, Pepcid, AC, Rolaids, Etc.
- ☐ Chemotherapy
- ☐ Laxatives
- ☐ Ulcer Medications
- ☐ Antibiotic/Antifungal
- ☐ Anti-diabetic/Insulin
- ☐ Oral Contraceptives
- ☐ Hormones – if so What? _____ When? _____ Dosage? _____
- ☐ Relaxants/Sleeping Pills
- ☐ Thyroid
- ☐ Radiation
- ☐ Antidepressants
- ☐ Aspirin/Acetaminophen
- ☐ Cortisone/Anti-Inflammatory
- ☐ Heart Medications
- ☐ High Blood Pressure

Please List names of any medications you are currently taking: _____
_____
_____
_____
_____

Are you allergic to any drugs, and if so please list the names here: _____
_____
_____

Are you Lactose or Gluten Intolerant: (please circle one) LACTOSE GLUTEN BOTH

Are you allergic to any foods, and if so please list the names here: _____
_____
_____

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking: _____
_____
_____

~ Life Style ~

Dietary Habits – Describe the foods you normally eat:
BREAKFAST: _____
LUNCH: _____
DINNER: _____
SNACKS: _____

Do you consume the following…?			If so, how much?
1. Soda or carbonated beverages?	YES	NO	_____
2. White flour products?	YES	NO	_____
3. Fried food?	YES	NO	_____
4. Coffee?	YES	NO	_____
5. Fast food regularly?	YES	NO	_____
6. Sweets and/or refined carbohydrates?	YES	NO	_____
7. Alcoholic beverages?	YES	NO	_____
8. Any tobacco products?	YES	NO	_____

Are you a vegetarian? YES NO

Are you currently in an exercise program? YES NO How often? _____

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

~ Males Only ~

Have you had a vasectomy? YES NO When? _____
Reverse vasectomy? YES NO When? _____

Experienced any symptoms related to the vasectomy/reverse vasectomy? YES NO
If yes, please explain: _____
_____

Do you have any history of prostate problems? YES NO
If yes, please explain: _____
_____

When was your last prostate exam: _____
What were your most recent PSA results? _____ Date: _____
Does your bladder always feel full? YES NO SOMETIMES
Does ejaculation cause pain? YES NO SOMETIMES
Do you ever experience low sex drive? YES NO SOMETIMES
Do you have premature ejaculation? YES NO SOMETIMES

All men completing this form should now skip the next few sections and start again in the section titled "Sleep" and continue with the remainder of this questionnaire.

~ Females Only: Reproductve Health History ~

(To be completed by all women, if applicable)

Age at onset of first period: _____ Approximate date of onset: _____

What are you using for contraception at the moment? _____

Have you ever used **oral**, **injection**, **patch**, or **ring** hormone contraceptives, or used Emergency Contraceptives ("The day after pill")? YES NO
If yes, from _____ to _____.
Did you suffer from any side effects from contraceptives? YES NO
If yes, please explain: _____

Are you currently or have you ever used an IUD? YES NO
When? _____ and for how long? _____

While under the use of any and all birth control methods, did you experience the following…
Yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.
(please circle and use extra space provided if explanation is needed)

_____
_____
_____
_____
_____

Are you currently, or have you ever used fertility treatments? YES NO
If yes, please explain: _____
_____

Are you currently, or have you ever used bio-identical hormones, such as DHEA, Pregnenolone, Progesterone, Estrogen, Testosterone, etc.? YES NO

If yes, what hormone(s), dosage and for how long? **Please be specific with dates of use.**

_____
_____
_____
_____

Do you have any history of abnormal Pap Tests? YES NO
If yes, please explain: _____
_____
Please describe any treatment/medication for this: _____
_____

Do you have any history of vaginal infections? YES NO
If yes, please describe: _____
_____
Please describe any treatment/medication for this: _____
_____

Do you have any history of the following conditions? (please circle appropriate answer)

Ovarian Cysts Fibrocystic Breasts Polycystc Ovarian Syndrom (PCOS)

Uterine Fybroids Endometriosis Lichen Sclerosis Vulvodynia

~ Females Only: Pregnancy History ~

(To be completed by all women, if applicable)

Have you been pregnant before? YES NO
If yes, please list the ages of your children: _____

Please explain important details/complications below:

Number of pregnancies: _____ _____
Number of live births: _____ _____
Number of miscarriages: _____ _____
How many weeks gestation at the time of miscarry? _____ weeks
Number of premature births: _____ _____
Number of cesarean births: _____ _____
Number of stillbirths: _____ _____
Number of ectopic pregnancies: _____ _____

All menopausal women should now skip the next few sections and start again in the section titled "Menopausal Women" and continue with the remainder of this questionnaire.

~ Females Only: Cycling History ~

(To be completed by all women who have not reached menopause)

What was the first date of your last menstrual period (LMP)? _____

Have you ever had tubal ligation surgery? YES NO
If yes, please list the date and specific details: _____
_____

Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle? (please circle appropriate answer)
<20days 20-30 days 30-40 days 40-50 days >50 days
What is the length of days your menstruation typically lasts? _____

Do you consider your cycle to be regular? YES NO NOT ALWAYS
Please explain: _____

What is your typical menstrual flow like? Light Medium Heavy
Please explain: _____

How many pads and/or tampons do you use on heavy days? _____ (circle) PADS TAMPONS BOTH
During menstruation, do you pass blood clots? YES NO If yes, how often? _____

How would you describe your camping? NONE MILD MODERATE SEVERE
At what point in your cycle do you experience the cramps? _____

Have you noticed any recent changes to your cycle? YES NO
If yes, please explain: _____

Do you experience any unusual or excessive vaginal discharge throughout the month?
YES NO When? _____

Do you experience any itching or odor in the vaginal area?
YES NO When? _____

Do you ever experience any breast tenderness? NONE MILD MODERATE SEVERE
If yes, at what point in your cycle? _____

DO you have nipple discharge at any point in your cycle? YES NO
If yes, at what point in your cycle? _____ Color? _____

All cycling women should now skip the next section and start again on the section labeled "Sleep" and continue on with the remainder of the questionnaire.

~ Females Only: Menopausal Women ~

(To be completed by all women who are no longer having a period)

What age were you at the onset of menopause? _____ Year of Onset? _____
Please describe any recent changes and/or symptoms associated with your cycle: _____
_____
_____
_____

Please List any and all GYN surgeries:	What was the reason for each surgery?
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Please give an in depth explanation of how you perceive your experience transitioning into menopause: (For example, please list symptoms, emotional changes, thoughts, stressors, etc.) _____
_____
_____
_____

Are you currently taking, or have you ever used conventional hormone replacement (HRT)? YES NO
If yes, please list the name of the prescription: _____
What is/was the dosage? _____ For how long? _____

Are you currently, or have you ever, used bio-identical hormone creams/gels/sublingual/troche/oral?
YES NO
If yes, please list the name(s) of the product(s): _____
What is/was the dosage? _____ For how long? _____

Are you currently, or have you ever, used any alternative, complimentary, or natural remedies to treat your menopause? YES NO
If yes, please list the name(s) of the product(s): _____
What is/was the dosage? _____ For how long? _____

Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? YES NO
If yes, what? _____
Treatment: _____

(Below please describe your previous cycle history.)

Would you have described your menstruation as: EASY UNCOMFORTABLE DIFFICULT DEBILITATING

What was your typical menstrual flow? LIGHT MEDIUM HEAVY
When you were cycling would you describe your cycle as regular? YES NO
If no, please explain: _____
_____

In the past, If you have ever received any type of "Treatment" for any cycle issues would you please explain: _____
_____
_____
_____

~ Sleep ~

How well do you sleep? (circle all that apply)

Well Trouble Falling asleep Trouble staying asleep Insomnia

What is the average number of hours you most often sleep each night? _____

Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO

If yes, how often? _____

Do you keep your room completely dark at night? YES NO

~ Signs & Symptoms ~

Instructions: circle the number that best describes the intensity of your current symptoms. 1 = mild (approximately once per month), 2 = moderate (approximately weekly), 3 = severe (almost daily). If you do not know the answer to a question or if it does not apply to you simply leave it blank.

Section 1:

Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestions?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water Retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/nausea? (circle)	1	2	3

Section 2:

Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
Persistent gas?	1	2	3
Digestive problems?	1	2	3

Section 3:

Low blood sugar/hypoglycemia?	1	2	3

Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine/stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

Section 4:

Low mood/depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

Section 5:

Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships? (circle)	1	2	3
Decreased initiative/motivation/drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness/crying? (circle)	1	2	3

Section 7:

Decrease in strength/stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decrease lean muscle mass?	1	2	3
Muscle soreness/weakness? (circle)	1	2	3
Body/joint aches? (circle)	1	2	3
Increased fat on hips/breasts/thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/migraines? (circle)	1	2	3
Muscle pain/joint aches/backaches?	1	2	3

Section 9:

Head hair loss/body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Section 10: (Females Only)

Infertility?	1	2	3
Lowered/heightened libido? (circle)	1	2	3
Hot flashes?	1	2	3
Night sweats?	1	2	3
Palpitations?	1	2	3
Breast tenderness?	1	2	3
Breast cysts?	1	2	3
Vaginal infections/yeast infections? (circle)	1	2	3
Urinary frequency/incontinence/infections? (circle)	1	2	3
Changes to labia/clitorial tissue? (circle)	1	2	3
(Atrophy, thinning, discoloration, itching, burning, …)			
Vaginal changes (dryness, tearing, decreasing size)? (circle)	1	2	3
Bone loss/osteoporosis?	1	2	3
Endometriosis?	1	2	3
Pelvic Inflammatory Disease?	1	2	3
Cystitis?	1	2	3
Ovarian cysts?	1	2	3
Fibrodes?	1	2	3

Section 11: (Males Only)

Lowered Libido?	1	2	3
Erectile Dysfunction (ED)?	1	2	3
Pain w/ejaculation?	1	2	3
Frequent need to urinate?	1	2	3
Urination is delayed/strained/incomplete? (circle)	1	2	3
Pain with urination?	1	2	3
Blood in the urine?	1	2	3
Bone loss/osteoporosis?	1	2	3