Medical History and Symptoms Questionnaire

Women's Wellness Center
2950 Village Drive,
Fayetteville, NC 28304
Office: 910.323.3301
Fax: 910.323.4207

Demographics(test)

Date Completed: ____ / ______ / ______

First Name: ________________ **Middle Initial:** _____ **Last Name**: ________________

Address: ____

City: _____ State or Prov **Zip**: _______

Gender: M or F

Date of Birth: ___ / ___ / ______ **Age**: ____

Communication Methods

Phone (Preferred): ___ - ___ - __________

Type of Phone: Home / Mobile / Business

Approved for confidential/personal information: Approved / Not Approved

Phone (Secondary): ___ - ___ - ______

Type of Phone: Home / Mobile / Business

Approved for confidential/personal information: Approved / Not Approved

Phone (Fax): ___ - ___ - ______

Approved for confidential/personal information: Approved / Not Approved

E-Mail Address: __________ @ ________________________

Approved for confidential/personal information: Approved / Not Approved

***Emergency Contact*:**

Name: _____________________________ Telephone: ___ - ___ - ______

Relationship: ____________________________

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Physician Information

☐ **No Primary Care Physician** ☐ **No Specialist**

Primary Care Physician

Name: ______________________
Occupation: __________________
Address: _______________________
____
Phone: ____ - ____ - _______
Email: __________@___________

Specialist Physician

Name: _____________________
Occupation: _______________________
Address: _____________________
____
Phone: ____ - _____ - ______
Email: ______________@__________

Chief Goal:

Briefly explain why it is you came to see the physician:

Energy Level

Please rank the follow from 0 = zero energy to 10 = very energetic

What time do you awaken?	Level 1 - 10 ____	Did you eat? _____
1 hour after awaking	Level 1 - 10 ____	Did you eat? _____
10 AM (or 3 hrs after awake)	Level 1 - 10 ____	Did you eat? _____
Noon (or 5 hrs after awake)	Level 1 - 10 ____	Did you eat? _____
3-5 PM (or 7-9 hrs after awake)	Level 1 - 10 ____	Did you eat? _____
Dinner	Level 1 - 10 ____	Did you eat? _____
8 - 9 PM	Level 1 - 10 ____	Did you eat? _____
11 PM	Level 1 - 10 ____	Did you eat? _____

Sleep Pattern

What time do you go to bed? ________
How long does it take to fall asleep? ______________
How many hours do you sleep before you awaken for any reason? __________
Are you able to get back to sleep? _____________
Do you awaken in the morning feeling tired? True / False
Do you snore loudly? True / False
Do you often wake up with a headache? True / False

Past Medical History

Please check any medical conditions or health problems that you currently have or have had in the past?

Condition		Condition	
Headaches (Migraines, other)	❍ yes ❍ no	Heart Disease	❍ yes ❍ no
Seizures Disorder	❍ yes ❍ no	Chest Pain	❍ yes ❍ no
Recurrent sinus infections	❍ yes ❍ no	Irregular Heart Beat	❍ yes ❍ no
Seasonal allergies	❍ yes ❍ no	High Blood Pressure	❍ yes ❍ no
Psychiatric or Emotional Illness	❍ yes ❍ no	Blood Clotting problems	❍ yes ❍ no
Depression	❍ yes ❍ no	Bleeding disorder	❍ yes ❍ no
Anxiety or excessive stress	❍ yes ❍ no	Stroke/vascular disease	❍ yes ❍ no
Asthma	❍ yes ❍ no	Constipation/diarrhea	❍ yes ❍ no
Chronic bronchitis	❍ yes ❍ no	Hepatitis/Liver disease	❍ yes ❍ no
Lung or breathing problems	❍ yes ❍ no	Kidney disease	❍ yes ❍ no
Chronic Indigestion	❍ yes ❍ no	Menstrual disorders	❍ yes ❍ no
Stomach Ulcers	❍ yes ❍ no	Reproductive problems	❍ yes ❍ no
Intestinal Disease	❍ yes ❍ no	Prostate problems	❍ yes ❍ no
Skin problems/dermatitis	❍ yes ❍ no	Sexual/Libido problems	❍ yes ❍ no
Back Pain or Sciatica	❍ yes ❍ no	Tendonitis	❍ yes ❍ no
Herniated Disc	❍ yes ❍ no	Chronic pain problems	❍ yes ❍ no
Neck pain	❍ yes ❍ no	Shoulder problems	❍ yes ❍ no
Chronic Muscle or Joint Pain	❍ yes ❍ no	Osteoarthritis	❍ yes ❍ no
Carpal Tunnel Syndrome	❍ yes ❍ no	Rheumatoid Arthritis	❍ yes ❍ no
Fibromyalgia	❍ yes ❍ no	Artificial joint/implants	❍ yes ❍ no
Diabetes	❍ yes ❍ no	Cancer	❍ yes ❍ no
Thyroid disease	❍ yes ❍ no	Psoriasis or eczema	❍ yes ❍ no
Osteoporosis/Osteopenia	❍ yes ❍ no		

Allergies:

☐ No known allergies to medications

Antibiotics:	☐ Penicillin	☐ Sulfa	☐ Other antibiotic.(Please list):	
Prescription Medication:	☐ Morphine	☐ Dye allergies	☐ Codeine	☐ Aspirin
Environmental Allergies:	☐ Seasonal	☐ Pet allergies	☐ Food allergies	
Food Allergies:	☐ Peanuts	☐ Shellfish	☐ Soy	

Any other allergy?: (please list):
Please describe the reaction to the allergen listed above, was it life-threatening

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Over-the-counter (OTC) issues

Please check all products that you use regularly. Check all that apply

Pain Reliever

- ☐ Aspirin
- ☐ Acetaminophen (example: Tylenol®)
- ☐ Ibuprofen (example: Motrin IB®)
- ☐ Ketoprofen (example: Orudis KT®)
- ☐ Naproxen (example: Aleve®)

Cough and Cold

- ☐ Cough + cold reliever (ex: Triaminic)
- ☐ Cough suppressant (ex: Robitussin DM®)
- ☐ Antihistamine product (ex. ChlorTrimeton)
- ☐ Decongestant product (ex.: Sudafed)
- ☐ Other (please list)

Non-Prescription Sleep Aids

- ☐ Non-prescription Sleep aids (example: Unisom®, Sominex®, and Nytol®)
- ☐ Non-prescription Diet aids/weight loss products (example: Dexatril®)

Stomach Problems

- ☐ Anti-diarrhea Medication (examples: Imodium®, Pepto Bismol®, and Kaopectate®)
- ☐ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
- ☐ Antacids (examples: Maalox®, Mylanta®)
- ☐ Acid blockers (examples: Tagamet HB®, Pepcid C®, and Zantac 75®

Prescription Medications - Hormones

Hormones previously taken. (This includes birth control, female or male hormones, thyroid)

	Hormone Name	Strength	How often per day?	Year Started	Year Stopped
1					
2					
3					
4					

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Prescription Medications – Prescribed by a Physician

This includes any medication or therapy prescribed by a physician.

	Name of Medication	Strength: units in mgs, gms, IU, mcg	At what times do you take this medication?	Year Started.	Are you currently taking this medication?
1					
2					
3					
4					
5					

Nutritional/Natural Supplements:

This includes any pill, substance, or supplement that you bought at a store or pharmacy without a doctor's prescription.

	Supplement	Manufacturer	Major Ingredients	Strength of Ingredients	For what reason do you take this supplement
1					
2					
3					
4					
5					
6					
7					

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Social History

Do you have a lot of stress in your life? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use alcohol? ☐ Yes ☐ No
Do you meditate daily? ☐ Yes ☐ No
Do you drink coffee or products containing caffeine? ☐ Yes ☐ No
Are you employed? ☐ Yes ☐ No
If yes, what is your occupation? ______________________________
Is the job stressful? ☐ Yes ☐ No
Do you take breaks from working? ☐ Yes ☐ No
Is your job physically demanding? ☐ Yes ☐ No
Are you retired? ☐ Yes ☐ No
If yes, is retirement stressful? ☐ Yes ☐ No
Sexual Orientation (you may decline to answer)
☐ Heterosexual (Straight) ☐ Homosexual (Gay)
Martial Status:
☐ Single ☐ Divorced ☐ Married/Partnered
☐ Partner/Significant Others Name ______________________________
Do you have any children? ☐ Yes ☐ No
If so, kindly list their name and their ages: ______________________
Do they live with you? ☐ Yes ☐ No

Dietary Habits

☐ No special diet habits ☐ Avoids red meat ☐ Minimizes fat
☐ Minimizes Carbohydrates ☐ Vegetarian

☐ Emphasize fruits, grains and vegetables ☐ I try to eat a healthy diet

☐ I do not eat dairy / cheese ☐ I commonly eat at fat-food restaurants

I commonly consume: ☐ Coffee ☐ Regular soft drinks ☐ Diet soda
☐ Candy/chocolate ☐ Chips / crackers

Family History

Do you have a family member (mother, father, grandparents or sibling) with any of the following? You may use the abbreviations, and only these relations are of significance: M = mother, F = father, S = sister, B = brother, MGM = maternal grandmother, MGF = maternal grandfather, PGM = paternal grandmother, PGF = paternal grandfather.

☐ Breast Cancer — If so, relationship ______
☐ Prostate Cancer — If so, relationship ______
☐ Uterine Cancer — If so, relationship ______
☐ Ovarian Cancer — If so, relationship ______
☐ Colon Cancer — If so, relationship ______
☐ Fibercystic breast — If so, relationship ______
☐ Heart Disease or stroke — If so, relationship ______
☐ High Cholesterol — If so, relationship ______
☐ Diabetes — If so, relationship ______
☐ High Blood Pressure — If so, relationship ______
☐ Osteoporosis/Osteopenia — If so, relationship ______
☐ Alzheimer's disease — If so, relationship ______

Previous Tests

Have you had any of the following tests performed?

Mammography ☐ Yes ☐No
If yes, list month/year:
If yes, what was the result?

PAP Smear ☐ Yes ☐No
If yes, list month/year:
If yes, what was the result?

Uterine Ultrasound ☐ Yes ☐ No
If yes, list month/year:
If yes, what was the result?

Bone Density ☐ Yes ☐No
If yes, list month/year:
If yes, what was the result?

Stress Test: (Treadmill) ☐ Yes ☐No
If yes, list month/year:
If yes, what was the result?

Exercise History

Do you do exercises?	☐ Yes	☐ No
Do you do weight resistant exercises? (Lift weights)	☐ Yes	☐ No
Do you do aerobic exercises?	☐ Yes	☐ No

WOMEN ONLY SECTION

Gynecology History

At what age did you first have your period (menarche)? Age: _____
Have you ever had Premenstrual Syndrome (PMS)? ☐ Yes ☐No
Are you currently suffering from PMS? ☐ Yes ☐ No
Have you ever used oral contraceptives? ☐ Yes ☐ No
If so, how many years total?
Are you currently on birth control pills? ☐ Yes ☐ No
Which BCP was the most recent one?
Did you have any side effects from taking the pill? ☐ Yes ☐No
If yes, describe any problem(s):
Are you currently still menstruating? ☐ Yes ☐No
What date did your last period begin? Month/Day/Year

What date did the period before the last period begin? M/D/Y

Are your periods regular? ☐ Yes ☐No
Do you spot or bleed between periods? ☐ Yes ☐No
Pregnancy:
How many pregnancies have you been pregnant?
How many children did you deliver?
How many children are still living?
How many miscarriages?
Did you have a tubal ligation? ☐Yes ☐ No
If Yes, what year?
Have you had a hysterectomy (uterus removed)? ☐ Yes ☐ No
If Yes, what year?

Have your ovaries (ovary) been removed? ☐ Yes, both ☐Yes, only one ☐ No
If Yes, what year?
Did you ever have, or currently have:
☐ Uterine fibroids ☐ Endometriosis ☐ Ovarian Cysts ☐ Fibrocystic Breasts

SYMPTOMATIC QUESTIONNAIRE

PART 1:

Please check all of the symptoms you are currently experiencing.

Estrogen dominant

☐ Water retention (swollen ankles and hands)
☐ Breasts are swollen, overdeveloped, or tender
☐ You think you have low thyroid
☐ You store your fat in the front of your stomach, your hips and your thighs
☐ Palpitations
☐ Anxiety

Progesterone Deficient

☐ Snoring (and you did not before)
☐ Urinary leakage (urine does not stop or comes out at inappropriate times)
☐ Aches in joints
☐ Varicose veins
☐ Weird dreams
☐ Lower back pain

Androgen Deficiency

☐ Good energy when you wake up, and all through the day until just around 6-7pm when you are ready to take a nap
☐ Trouble remembering directions
☐ Trouble remembering number
☐ Difficult hold back tears/emotions
☐ Decreased libido
☐ Muscle weakness
☐ Diminished feeling of well being

Adrenal Fatigue

☐ Fatigue, especially around 2 to 4pm
☐ Allergies are worse
☐ Craving for salt and sugar
☐ Chemical or other sensitivities that you never had before
☐ You wake up after 3 hours of being asleep then you are unable to go to sleep for a few hours, until the last portion of the night between before you wake up.
☐ After a stressful day, you feel worn out
☐ When you miss a meal, you get irritable or weak
☐ Difficult keeping your focus and concentration
☐ When you get a cold, it seems to last a long time
☐ In the past you were an "adrenaline junkie" (liked daring thrills) but now you avoid those situations.
☐ Age spots appearing on arms and face

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Adrenal Stress

- ☐ At night, you lie awake unable to fall asleep, but your body is tired
- ☐ You are stressed, but you are able to handle it.
- ☐ You are an "adrenaline junkie", you like daring thrills
- ☐ Hair loss all over your head.
- ☐ Weight gain, especially in front of stomach, love handles and face
- ☐ Anxiety
- ☐ Craving for sweets
- ☐ You currently work best under pressure
- ☐ After something eventful happens, you feel energized

Thyroid Deficiency

- ☐ Fatigue constant through the day
- ☐ Low stamina
- ☐ Cold hands and feet
- ☐ Intolerance to cold (you do not like winter because of the coldness)
- ☐ Weight gain
- ☐ Hair loss all over your head
- ☐ Swollen, puffy eyes
- ☐ Brittle nails

Thyroid Excess

- ☐ Nervousness
- ☐ Irritable or angry
- ☐ Hand tremors
- ☐ Insomnia
- ☐ Palpitations (skipped heartbeats)
- ☐ Weight loss even though you are not dieting
- ☐ Diarrhea
- ☐ Warm hands and feet

GH Deficiency

- ☐ General muscle loss
- ☐ "Pot belly"
- ☐ More facial wrinkles
- ☐ Reduced exercise capacity
- ☐ Loss of concentration
- ☐ Loss of self confidence/self esteem
- ☐ Decreased in quality of sleep
- ☐ Sagging cheeks
- ☐ Thinning lips

PART 2: Women Only

Estrogen Loss

- ☐ Hot flashes
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Dry skin, eyes, or mouth
- ☐ Breast have become smaller, droopy
- ☐ Foggy thinking
- ☐ Forget names of people or objects
- ☐ Painful intercourse
- ☐ Hair loss on the crown of head

Androgen Excess

- ☐ Acne
- ☐ Hair loss in the front
- ☐ Hair on face and nipple area
- ☐ Deepening of voice
- ☐ Clitoral enlargement
- ☐ Irritability/moodiness
- ☐ Insomnia

Progesterone Deficiency

- ☐ Your periods are Irregular or have stopped
- ☐ Headaches before or during your periods

Women on hormone therapy (natural or synthetic)

- ☐ Progesterone Excess
- ☐ Feeling sedated
- ☐ Heartburn
- ☐ Gastrointestinal bloating
- ☐ Depression with loss of interest
- ☐ Frequent yeast Infections