IRIE NATURAL HEALTH CENTER
Feeling good the natural way
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FEMALE GENERAL HEALTH HISTORY QUESTIONNAIRE

PATIENT INFORMATION:			
Name			Date
Height	Weight	DOB	Age

WHAT IS YOUR MAJOR SYMPTOM/PROBLEM?	DATE SYMPTOM BEGAN
1.	
2.	
3.	
4.	
5.	

PAST HEALTH HISTORY:	CIRCLE ALL THAT APPLY
Cardiovascular disease:	chest pain/heart failure/ murmur/ high blood pressure/ vascular disease/ blood clots/ fainting/ lower extremity edema / elevated blood lipids or homocysteine / heart murmur / mitral valve prolapse / palpitations
Respiratory disease:	shortness of breath/asthma/ bronchitis/ pneumonia/ allergies/ hay fever / chest pain / chronic cough
Gastrointestinal disease:	heart burn/ gall bladder disease /gall bladder stones /diarrhea/constipation / hepatitis/ IBS / bloating /cramps or pain / nausea or vomiting / change in bowel habits/ bloody tarry stools/ hemorrhoids
Genitourinary disease:	overactive bladder/ frequent urination / pain with urination / urinary incontinence /blood in urine / inability to hold urine / inability to empty bladder
Breast disease	nipple discharge/ changes in skin on or around your breast/ lumps/ history of breast disease (fibrocystic, or tumor)
Pelvic disease	vaginal discharge/ vaginal itching / pelvic pain/ pain with intercourse/ endometriosis/ ovarian cysts/ uterine fibroid/ PID/ toxic shock syndrome.
Other:	fever/ chills / rashes /autoimmune disease/ fibromyalgia/ hypothyroidism/ low temperate syndrome/ rheumatoid arthritis/ headaches / swollen face /puffy hands/ skin bruising / cold intolerances/dizziness /diabetes/ high blood pressure/ cancer/ depression/ high cholesterol/ sleep apnea/ childhood diseases/ German measles /chicken pox / rubella / blood transfusions / HIV /rheumatic fever / chronic fatigue/epstein-barr, fractures, arthritis / unexplained weight loss / loss of appetite / night pain

MEDICATIONS: (All medication including aspirin or vitamin supplements)	DOSAGE	HOW OFTEN TAKEN

ALLERGIES TO MEDICATION	
Name the Drug	Reaction You had

GENERAL AND SOCIAL HEALTH HISTORY

When was your last blood work? _____
Any seizure history? □ Y □N
Are you currently taking anticoagulants such as Aspirin, Warfarin or Coumadin? □ Y □N
Do you smoke cigarettes? □ Y □N #per day _____ Former Smoker? □
Do you drink alcohol? □ Y □N □ occasionally
Do you drink coffee? □ Y □N How many cups daily? _____
Any history of illegal steroid use, Past or Present? □ Y □N
Are you currently receiving bio-identical hormone replacement therapy? □ Y □N
Date hormone therapy began? _____ Are you responsive to the therapy? □ Y □N
Any side effects experienced from receiving bio-identical hormone replacement therapy? □ Y □
Are you currently working? □ Y □N Occupation? _____
Do you feel anxious? □ Y □N Depressed? □ Y □N Panic Attacks? □ Y □N
Are you taking any psych meds? □ Y □N

HOSPITALIZAIONS AND OPERATIONS	
DATES	DIAGNOSIS/OPERATION

MENSTRUAL CYCLE HEALTH
Age at first period? _____
Is your period cycle regular (every month) □ Y □N
Is your period cycle irregular (not every month) □ Y □N
How many days does your menstrual period last? _____
What is the number of days between first day of one period and first day of the next one? _____
Is your menstrual flow: □ Heavy □ Moderate □ Light #pads/tampons used on heaviest day? _____ Date of last period? _____
What color is the blood? □ bright red □ dark red □ light red
Do you notice blood clots during your menstrual period? □ Y □N

Do you have any PMS symptoms? □ breast tenderness □ bloating □ irritability □ headaches □ cravings
Are your symptoms relieved by the by the start of your period? □ Y □ N

Are your menstrual periods painful? □ Y □ N

If yes, Circle below the severity of your menstrual cramp pain on a scale of 0-10
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Any history of sexual, mental/emotional physical abuse? □ Y □ N
If so, at what age and by whom? _____

PREGNANCY HISTORY

Total number of pregnancies? _____
Number of Preterm Deliveries? _____
Number of Term Deliveries? _____
Abortion/miscarriages? _____
Number of Living Children? _____
Birth complications such as (hemorrhage, infection, c-section, toxemia, blood sugar or blood pressure problems?

_____
_____

GYENCOLOGICAL HISTORY

Date of last pap smear? _____
Any abnormal Pap Smears? □ Y □ N
Have you had gynecological surgery? □ No □ Hysterectomy
Do you have your ovaries? □ Y □ N Do you have your cervix? □ Y □ N
Family history of any hormone cancer (breast, ovarian)? □ Y □ N
Are you sexually active? □ Y □ N □ Male partner □ Female partner □ Both
How many sexual partners do you currently have? _____
Is it possible you are pregnant? □ Y □ N
Are you using birth control? □ Y □ N
Date of last breast exam? _____ Any abnormal results? □ Y □ N
History of breast surgery? □ None □ Implants (date implanted/type) _____
Date of last mammogram? _____ □ Normal □ Abnormal, finding:

MENOPAUSE HISTORY:

Do you experience any menopausal symptoms: □ Y □ N □ hot flashes □ vaginal dryness □ insomnia □ mood changes □ decreased libido □ spotting □ Acne □ joint pain □ night sweats □ irregular menses □ hair loss □ fatigue □ sleep disruption □ palpitations □ incontinence □ facial hair □ Glucose intolerance □ decreased memory
Last bone density scan? _____ □ Never

Nutritional Health History
Circle the level of stress you are experiencing on a scale of 1to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (eg work, finances, relationship(s) etc) _____
What is your overall energy level on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Do you sleep through the night? Y □N Do you wake rested? □ Y □N
Do you consider yourself: □ underweight □ overweight □ just right
Your weight today_____lbs Your weight at age 20_____lbs Your ideal weight_____lbs
Have you had unintentional weight loss or gain of 10 pounds or more in the last three months? □ Y □N
Do you make/eat home cooked meals? □ Y □N Do you eat fast food meals? □ Y □N # _____ times/ weekly
What are your eating habits? □ One meal per day □Two meals per day □Three meals per day □Graze (small frequent meals) □Eat constantly whether hungry or not
Glasses of water/day____ Cups of coffee per day _____ Energy Drinks (Monsters/Red Bull) per day_____ Sodas/day ____ diet soda? □ Y □N □ Laxative use □ Y □N
Exercise history: □None □1 to 2 days per week □ 3 to 4 days per week □ 5 to7 days per week □Less than 45 minutes per workout □ More than 45 minutes per workout
Do you tend to be sensitive to medications? □ Y □N
Any history of drug abuse or addiction? □ Y □N
Are you currently taking any medication you would like to discontinue? □ Y □N Name of medication(s)? _____
Are you particularly sensitive to perfumes, gasolines, or other vapors? □ Y □N
Do you use pesticides, herbicides or other chemical around you home? □ Y □N
LIST ALL PREVIOUS AND CURRENT TREATMENT:
1.
2.
3.
4.
How committed are you to making a change in your health? (1=least, 10=most committed): 1 2 3 4 5 6 7 8 9 10
I Would like to: □ Feel more vital □Feel less pain □Lose weight □Improve memory □Be less indecisive □Increase sex drive □ Use less medication □Have more endurance □Sleep better □Be stronger □Be less moody □Feel more motivated □Increase muscle tone □Slow down aging □ Other_____