

Vitalia Holistic Health Centre

New Patient Questionnaire

Date ____/____/____

Last Name _____ First _____ Middle Initial _____ Age _____

Date of Birth ____/____/____ Do you have a name you prefer to be called by? _____

Address _____ City _____

State _____ Zip Code _____ - _____ Email _____

Home # _____ Work # _____ Cell# _____

Social Security Number _____ - _____ - _____ What is your height? _____ Weight? _____

Level of education? (Circle) High School College Graduate School Other _____

How did you learn about us? Please circle and provide specifics where appropriate.

Friend Family Patient Physician Lecture Ins Co Food Store Phone Book

Specifically _____

Are you employed? (circle) Yes No If yes, what is your occupation? _____

Employer _____

Are you covered by medical insurance? (circle) Yes No If yes, who? _____

Who will be responsible for payment of services? _____

What is your present social status? Please circle current one. Single Married Divorced Widowed
Cohabiting

Do you participate in any sports? (circle) Yes No If yes, which _____

Are you a member of a health club? (circle) Yes No If yes, which _____

Do you smoke ? (circle) Yes No If yes, how much? _____ How long? _____

Do you consume alcohol? (circle) Yes No What kind(s)? Beer Wine Liquor # of drinks per month _____

Do you take any nutritional supplements or herbs? (circle) Yes No

Please list the radio stations and TV shows you listen to/watch _____

Have you seen any alternative medicine practitioners? (circle) Yes No If so, which type? _____

What health concerns would you like to discuss in your initial visit? Please list your concerns in order of importance.

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

What are your thoughts on these concerns? Do you have any ideas as to what might be the underlying cause of your symptoms? Please explain. (You may attach additional pages if necessary.)

When was the **last time you experienced optimal health?** _____

What do you feel your weakest organ system (i.e., heart, kidney, etc.) is, and why? _____

Please write the specific health results you would like to achieve in working with the doctor. _____

What are you willing to do to achieve the health results you just recorded? If your physician were to recommend the following choices which would you be able to follow and comply with or not? Please check YES or NO.

| ITEM | YES | NO | ITEM | YES | NO |
|---|-----|----|---|-----|----|
| Make dietary modifications | | | Take nutritional supplements daily | | |
| Avoid certain foods | | | Be compliant with the treatment | | |
| Exercise Regularly | | | Stick with the program for at least 6 months | | |
| Read books, handouts or listen to tapes for self education about health | | | Keep the doctor informed about what part of the program is and is not working for you | | |

If you are in a relationship, will your **significant other support you** in your dietary or lifestyle modification(s)? Yes No

What is your present living situation? Please check all that apply. Alone With Spouse With Parent(s)

With Child or Children With Relative(s) With Friend(s) With Significant Other(s)

Name of spouse, parent, relative, friend, or significant other _____

Next of kin/person to contact in the event of an emergency _____

Address _____

City _____ State _____ Zip Code _____ - _____

Telephone (Home) _____ Telephone (Work) _____

What is your relationship to this person? _____

Do you have children? Yes No Do your children live with you? Yes No List your children by name and age.

When did you last receive medical care? ___/___/___ Where? _____

What condition(s) were you treated for? _____

Current health care provider? _____

Address _____ City _____

State _____ Zip Code _____ - _____ Telephone _____

How many times do you get colds, flues, sinusitis, sore throats, bronchitis or other infections annually? _____

How long do these usually last? _____ Are these conditions severe? Yes No

Have you ever been diagnosed as having a worm or parasite infection? Yes No If yes, when? ___/___/___

Have you ever suspected that you might be experiencing a worm or parasite infection? Yes ___ No ___

Do you camp outdoors? Yes ___ No ___ Have you lived or traveled outside the United States? Yes ___ No ___

If yes, when and where? _____

PERSONAL HEALTH HISTORY Please indicate any condition(s) of past or present concern:

| PAST | PRESENT | CONDITION | PAST | PRESENT | CONDITION |
|-------------|----------------|--------------------------------------|-------------|----------------|-------------------------------|
| ___ | ___ | Alcoholism | ___ | ___ | Heart Disease |
| ___ | ___ | Anemia | ___ | ___ | Heart Murmur |
| ___ | ___ | Arthritis | ___ | ___ | Herpes |
| ___ | ___ | Asthma | ___ | ___ | High Blood Pressure |
| ___ | ___ | Bleeding (Excessive or Uncontrolled) | ___ | ___ | Injury (Life-Threatening) |
| ___ | ___ | Cancer | ___ | ___ | Kidney Disease |
| ___ | ___ | Colitis | ___ | ___ | Liver Disease |
| ___ | ___ | Constipation | ___ | ___ | Lyme Disease |
| ___ | ___ | Diabetes | ___ | ___ | Mononucleosis |
| ___ | ___ | Digestive Disorders | ___ | ___ | Osteoporosis |
| ___ | ___ | Eczema | ___ | ___ | Pneumonia |
| ___ | ___ | Emphysema | ___ | ___ | Rheumatism |
| ___ | ___ | Epilepsy | ___ | ___ | Seizures |
| ___ | ___ | Glaucoma | ___ | ___ | Sexually Transmitted Diseases |
| ___ | ___ | Gout | ___ | ___ | Sinusitis |
| ___ | ___ | Hay Fever | ___ | ___ | Stroke |
| ___ | ___ | Headaches | ___ | ___ | Thyroid (Hyper or Irregular) |
| ___ | ___ | Heart Attack | ___ | ___ | Tuberculosis |

What was the date of your **last complete physical exam?** ___/___/___ Was **blood work performed?** Yes No

What was the date of your last chest x-ray? ___/___/___

Has any relative under the age of 60 died as the result of a heart attack? Yes ___ No ___ Who? _____

Has any female in your immediate family experienced breast cancer? Yes ___ No ___ Who? _____

Have you ever been hospitalized? Yes ___ No ___ If yes, please provide specifics where indicated below.

| Condition Treated or Surgical Procedure Performed | Date | Hospital |
|--|-------------|-----------------|
| _____ | ___/___/___ | _____ |
| _____ | ___/___/___ | _____ |
| _____ | ___/___/___ | _____ |
| _____ | ___/___/___ | _____ |

If yes, please list.

| Prescription or Medication | Condition Prescribed For | Prescribing Physician |
|-----------------------------------|---------------------------------|------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are you taking any vitamins, minerals, herbs or nutritional supplements? Yes ___ No ___ If yes, please list.

| Vitamin\Mineral\Herb\Nutritional Supplement | Condition Taken For | Recommended By |
|---|---------------------|----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Are you allergic to any foods, drugs or other substances? Yes ___ No ___ If yes, please list.

| Food\Drug\Substance | Allergic Reaction(s) |
|---------------------|----------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

FAMILY HEALTH HISTORY

Is any blood relative or member of your immediate family presently experiencing any of the following conditions? Please use the following codes to denote the person affected. **M** for your Mother. **F** for your Father. **B** for your Brother. **S** for your Sister. **GM** for your Grandmother. **GF** for your Grandfather. **A** for your Aunt. **U** for your Uncle. **W** for your Wife. **H** for your Husband. **SO** for your Significant Other.

| PAST | PRESENT | CONDITION | PAST | PRESENT | CONDITION |
|------|---------|--------------------------------------|------|---------|---------------------------|
| ___ | ___ | Alcoholism | ___ | ___ | Heart Disease |
| ___ | ___ | Anemia | ___ | ___ | Heart Murmur |
| ___ | ___ | Arthritis | ___ | ___ | Herpes |
| ___ | ___ | Asthma | ___ | ___ | High Blood Pressure |
| ___ | ___ | Bleeding (Excessive or Uncontrolled) | ___ | ___ | Injury (Life-Threatening) |
| ___ | ___ | Cancer | ___ | ___ | Kidney Disease |
| ___ | ___ | Colitis | ___ | ___ | Liver Disease |
| ___ | ___ | Constipation | ___ | ___ | Lyme Disease |
| ___ | ___ | Diabetes | ___ | ___ | Mononucleosis |
| ___ | ___ | Digestive Disorders | ___ | ___ | Osteoporosis |

PAST PRESENT CONDITION

____ ____ Eczema
____ ____ Emphysema
____ ____ Epilepsy
____ ____ Glaucoma
____ ____ Gout
____ ____ Hay Fever
____ ____ Headaches
____ ____ Heart Attack

PAST PRESENT CONDITION

____ ____ Pneumonia
____ ____ Rheumatism
____ ____ Seizures
____ ____ Sexually Transmitted Diseases
____ ____ Sinusitis
____ ____ Stroke
____ ____ Thyroid (Hyper or Irregular)
____ ____ Tuberculosis

PERSONAL EMOTIONAL HISTORY

Please list the 5 most stressful events in your life in descending order of importance and indicate whether or not they are still impacting your life.

- 1 _____ Yes No
2 _____ Yes No
3 _____ Yes No
4 _____ Yes No
5 _____ Yes No

Please list any **major decision(s)** you are presently facing.

Please **list any major change(s)** in your life that you experienced recently or expect to experience in the near future.

Do you **presently experience** any of the following on a regular basis? Please check all that apply.

- Loneliness Sadness Crying Spells Depression Despair Suicidal Thoughts Fatigue
Tension Low Threshold for Frustration Anxiety Fear Panic Attacks Nightmares
Obsessive or Compulsive Behavior(s) Jealousy Possessiveness Shyness Inability to Communicate

When something troubles you, how do you deal with it? Please check the answer that best characterizes your response.

- I don't. I deny or avoid it. I deal with it independently, directly and privately.
 I discuss it with a loved one. I discuss it with a friend. I discuss it with a clergy person or counseling professional.

Are you currently being or have you been **abused** in any way? Yes No

If yes, by whom? _____

Do you **love** yourself? Yes No Don't Know Is it easy for you to **forgive** yourself and others? Yes No

Is there **anyone in your life you have not forgiven** and harbor resentment toward? Yes No If yes, please list.

Rate your **self esteem**. Very Low Low Moderate High Very High

Are you consulting a clergy person or counselor? Yes No If yes, whom? _____

Are you sexually active? Yes No

Do you own a gun or are there guns stored in your residence? Yes No

OCCUPATION If presently employed, how many hours per week do you work? _____

Please describe the nature of your work and the responsibilities associated with it. _____

What is your **stress level at work**? Non-Existent Low Mild Moderate High Severe

What is your **satisfaction level at work**? Non-Existent Low Mild Moderate High Extremely High

Are you doing the **type of work that you would most enjoy** above all else? Yes No

Do you work indoors? Yes No Do you work in an office building? Yes No

Do the windows open for ventilation? Yes No Is there specialized air filtration in your workplace? Yes No

Do you presently **work with chemicals or in the presence of toxic fumes**? Yes No Have you ever? Yes No

Do you have **hobbies or interests** outside of work? Yes No If yes, please describe. _____

HOUSEHOLD

Do you **live or work close to** any of the following types of areas? Please check as many as you feel apply.

Busy Road Body of Water Wooded Area Power Lines Microwave Transmitter Smoke Stack

Dump Marsh Wetlands **Is your lawn or are neighboring lawns sprayed with chemicals?** Yes No

Where does your **source of electrical power** enter your home? _____

Do you have **any housepets**? Yes No If yes, what type(s)? _____

HABITS

Do you exercise? Yes No If yes, what type(s)? _____

If yes, **how often** per week? _____ If yes, for **what duration?** _____

Do you have an alcoholic family member or loved one? Yes No If yes, who? _____

Are you **exposed to second-hand smoke?** Yes No Do you **consume coffee?** Yes No

How many cups of coffee do you consume daily? _____ What do you **put in your coffee?** _____

If yes, do you drink regular, decaffeinated or both? Regular Decaffeinated Both

Which **types of water** do you consume or cook with? City Tap Well Filtered Distilled Spring
(Ask us about water filtration options if you are drinking from the tap)

How many glasses of water do you consume daily? _____ Is your water fluoridated? Yes No

Do you **consume sugar** (in cakes, pies, candies, chocolate, ice cream, soda, junk food, etc.)? Yes No

If yes, how many sugar treats per day or week? _____

Do you **consume sodas** containing caffeine? Yes No If yes, how many cups do you consume daily? _____

Do you **consume teas**, either regular or iced? Yes No If yes, how many cups do you consume daily? _____

Do you **use recreational drugs or marijuana?** Yes No

If yes, what type(s)? _____ If yes, how often? _____

How many **hours do you sleep nightly?** _____ What time do you fall asleep? _____ What time do you awake? _____

How would you characterize your sleep? Fitful Erratic Calm Restful Deep

Upon awakening, do you feel well-rested and energetic? Yes No Do you nap during the day? Yes No
If yes, for what duration? _____

Do you sleep on an electrically-heated water bed? Yes No Do you sleep under an electric blanket? Yes No

How would you **characterize your energy on a daily basis?** Very Low Low Moderate High Very High

Do you spend time outside daily? Yes No

If yes, are you regularly exposed to the sunlight without glasses or other protective eyewear? Yes No

Do you feel that you have **adequate leisure time?** Yes No

When you have leisure time, do you feel that you are **able to relax completely and enjoy it?** Yes No

If no, please explain. _____

Please list your favorite leisure activities. _____

When did you last take a vacation? ____/____/____ For what duration? _____

Do you use a toothpaste or oral rinse containing fluoride? Yes No

We recommend you don't.

Do you use a deodorant with aluminum? Yes No

We recommend you don't.

Do you use **mothballs?** Yes No Do you use **chemical pest controls?** Yes No **We recommend you don't.**

Do you use laxatives? Yes No If yes, what type(s)? _____ How often? _____

On average, **how often do your bowels move?** # of times daily _____ # of times weekly _____

Characterize your stools. Use the following codes to denote frequency: **I** for Infrequently - **F** for Frequently - **C** for Constantly.

- _____ Small (6 inches or less in stool over a 24 hour period)
- _____ Medium (12 inches or more in stool over a 24 hour period)
- _____ Large (18 inches or more in stool over a 24 hour period)
- _____ Loose but not watery
- _____ Diarrhea
- _____ Alternatively hard and loose and/or watery
- _____ Medium brown in color
- _____ Dark brown in color
- _____ Black in color
- _____ Yellow, light brown or clay-colored
- _____ Green in color
- _____ Containing blood
- _____ Containing mucus
- _____ Containing undigested food

Do you have **intestinal gas?** Yes No If yes, is it : Occasional Frequent Excessive Painful Smelly

Do you have **trouble initiating bowel movements** for which the stool is neither large or hard? Yes No

Do you experience **abdominal discomfort or cramping with bowel movements?** Yes No

If yes, Please circle all that apply. Occasionally Frequently Always

Have you ever been diagnosed with a stomach, liver, gallbladder, pancreas, or bowel disease? Yes No

Do you respond promptly to urges to defecate? Yes No

Please review the list of conditions, **check ONLY those items you are experiencing AT THE PRESENT TIME.**

- | | |
|---|--|
| <input type="checkbox"/> Rough, Dry or Scaly Skin | <input type="checkbox"/> Fever or Chills |
| <input type="checkbox"/> Psoriasis or Eczema | <input type="checkbox"/> Intolerance to Heat |
| <input type="checkbox"/> Itching Skin | <input type="checkbox"/> Intolerance to Cold |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Excessive Hunger |
| <input type="checkbox"/> Brittle Nails | <input type="checkbox"/> Inability to Gain Weight |
| <input type="checkbox"/> Burning Skin | <input type="checkbox"/> Change or Loss of Sensation |
| <input type="checkbox"/> Boils or Canker Sores | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Seizures or Epilepsy |
| <input type="checkbox"/> Skin Color Change | <input type="checkbox"/> Shaking or Trembling |
| <input type="checkbox"/> Hair Color Change | <input type="checkbox"/> Lightheadedness upon Standing |

New Patient Questionnaire

- | | |
|--|--|
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Trauma or Injury to the Head | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Unexplained Fever |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Burst of Energy Following Exercise |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Difficulty Concentrating |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Difficulty Relieving Stress |
| <input type="checkbox"/> Restlessness | <input type="checkbox"/> Fitful Sleep |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Pain in Ears | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Excessive Earwax |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Joint Pain, Stiffness or Swelling | <input type="checkbox"/> Discharge from Ears |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of hearing |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Frequent Fracturing of Bones |
| <input type="checkbox"/> Unexplained Weight Gain or Loss | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Overweight | <input type="checkbox"/> Damp Eyes |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Caked or Crusted Eyelids |
| <input type="checkbox"/> Increased Thirst | <input type="checkbox"/> Sensitivity to Light |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Poor Eyesight |
| <input type="checkbox"/> Wounds Slow to Heal | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Swelling of Neck | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Change in Vision |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Blurred Vision |
| <input type="checkbox"/> Unusual Growths of Hair | <input type="checkbox"/> Loss of Vision |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Post Nasal Drip |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Sore Gums |
| <input type="checkbox"/> Discharge from Nose | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Discharge from Nose During or After Meals | <input type="checkbox"/> Sore Mouth or Tongue |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Sensitive Teeth |
| <input type="checkbox"/> Difficulty Breathing Through Nose | <input type="checkbox"/> Impairment or Loss of Sense of Taste |
| <input type="checkbox"/> Obstruction of Nose | <input type="checkbox"/> Increase or Decrease of Saliva |
| <input type="checkbox"/> Impairment or Loss of Sense of Smell | <input type="checkbox"/> Persistent Hoarseness |
| <input type="checkbox"/> Difficulty Speaking | <input type="checkbox"/> Frequent or Daily Coughs |
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Shortness of Breath at Rest | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Shortness of Breath at Play | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gallbladder Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Discharge from Throat with Blood and/or mucus |
| <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Chest Pain at Rest |
| <input type="checkbox"/> Chest Pain at Play | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Frequently Awake at Night Hungry |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Irritable if Late for a Meal |
| <input type="checkbox"/> Swelling of Ankles | <input type="checkbox"/> Sudden Cravings for Sweets or Alcohol |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Headaches or Tremors Relieved by |
| <input type="checkbox"/> Sleep in an Upright Position | <input type="checkbox"/> Consuming Sweets |
| <input type="checkbox"/> Frequently Awake at Night Short of Breath | <input type="checkbox"/> Frequent Heartburn or Indigestion |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Frequent Stomach or Abdominal Pain |
| <input type="checkbox"/> Frequent Night Urination | <input type="checkbox"/> Frequent or Excessive Belching |
| <input type="checkbox"/> Frequent Urgent Urination | <input type="checkbox"/> Frequent or Severe Nausea |
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Discomfort After Fatty or Greasy Meals |
| <input type="checkbox"/> Difficulty Holding Urine | <input type="checkbox"/> Lack of Energy After Meals |

New Patient Questionnaire

- | | |
|---|--|
| <input type="checkbox"/> Difficulty Initiating Urination | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Frequent Urinary Infections | <input type="checkbox"/> Yellow Stools |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Blood in Stools |
| <input type="checkbox"/> Malodorous Stools | <input type="checkbox"/> Abdominal Bloating |
| <input type="checkbox"/> Anal Itching | <input type="checkbox"/> Excessive Lower Bowel Gas |
| <input type="checkbox"/> Stomach Pain 5-6 hours after meal (usually at night) | <input type="checkbox"/> Symptoms Above Relieved By Drinking Milk |
| <input type="checkbox"/> Symptoms Above Aggravated by Worry or Tension | |
| <input type="checkbox"/> Discharge from Vagina | <input type="checkbox"/> Discharge from Penis |
| <input type="checkbox"/> Difficulty Feeling Sexually Aroused | <input type="checkbox"/> Difficulty Achieving or Maintaining Erection |
| <input type="checkbox"/> Lack of Lubrication When Aroused | <input type="checkbox"/> Painful Erection |
| <input type="checkbox"/> Never or Seldom Experience Orgasm | <input type="checkbox"/> Difficulty Ejaculating |
| <input type="checkbox"/> Find Sexual Intercourse to be Painful | <input type="checkbox"/> Lumps, Swelling or Pain in Testicles or Groin |
| <input type="checkbox"/> Cold Hands and/or Feet | <input type="checkbox"/> Menstrual Flow is Excessive/Decreased/Absent |
| <input type="checkbox"/> Troubling Veins in Legs | <input type="checkbox"/> Bleeding or Spotting Between Periods |
| <input type="checkbox"/> Pain in Legs | <input type="checkbox"/> Pain Before, During and/or After Periods |
| <input type="checkbox"/> PMS (Cramping, Headaches, Water Retention) | <input type="checkbox"/> Swollen or Painful Lymph Nodes |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Easily Bruised |
| <input type="checkbox"/> Must Sleep in an Upright Position | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Clots in Menstrual Flow |
| <input type="checkbox"/> Mood Swings with Menstruation | <input type="checkbox"/> Mood Changes with Menstruation |
| <input type="checkbox"/> Increased Acne, Irritability or Weight with Menstruation | <input type="checkbox"/> Pelvic Pain |
| <input type="checkbox"/> Lumps or Pain in Breasts | <input type="checkbox"/> Discharge from Breasts |

WOMEN:

I HAVE REGULAR PERIODS: Period every ____ days. Period lasts ____ days.

Number of Tampons, Pads or Sponges Used Daily? ____ Date of Last Period? ____/____/____

I HAVE IRREGULAR PERIODS: Period usually every _____ days. Period lasts _____ days.

Number of Tampons, Pads or Sponges Used Daily? ____ Date of Last Period? ____/____/____

Form of Contraception Used? _____ Number of Pregnancies? ____

Complications of Pregnancy _____

Number of Births? ____ Number of Miscarriages? ____ Number of Abortions? ____

Complications Associated with Any of the Above _____

Age at Onset of Menopause? ____ Menopausal Symptoms _____

Date of **Last Pap Smear?** ____/____/____

Date of **Last Mammogram?** ____/____/____

Have You Ever Had An Abnormal Or Irregular Pap Smear? Yes No When? ____/____/____

Have You Ever Had An Abnormal Or Irregular Mammogram? Yes No When? ____/____/____