



Medical History and Symptoms Questionnaire

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

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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

Specialist Physician

Name: _____

Name: _____

Occupation: _____

Occupation: _____

Address: _____

Address: _____

Phone: ____ - ____ - _____

Phone: ____ - ____ - _____

Email: _____@_____

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? ____



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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?

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

Marital 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



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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.

- | | |
|--|---------------------------|
| <input type="checkbox"/> Breast Cancer | If so, relationship _____ |
| <input type="checkbox"/> Prostate Cancer | If so, relationship _____ |
| <input type="checkbox"/> Uterine Cancer | If so, relationship _____ |
| <input type="checkbox"/> Ovarian Cancer | If so, relationship _____ |
| <input type="checkbox"/> Colon Cancer | If so, relationship _____ |
| <input type="checkbox"/> Fibercystic breast | If so, relationship _____ |
| <input type="checkbox"/> Heart Disease or stroke | If so, relationship _____ |
| <input type="checkbox"/> High Cholesterol | If so, relationship _____ |
| <input type="checkbox"/> Diabetes | If so, relationship _____ |
| <input type="checkbox"/> High Blood Pressure | If so, relationship _____ |
| <input type="checkbox"/> Osteoporosis/Osteopenia | If so, relationship _____ |
| <input type="checkbox"/> 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you do weight resistant exercises? (Lift weights) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you do aerobic exercises? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



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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



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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



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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