WOMEN'S HEALTH INTAKE FORM

PATIENT INFORMATION

Name:		Date:
Date of Birth:	Age:	Gender: ☐ Female ☐ Male
Address:		
City, State, Zip:		
Phone 1: May we leave messages at this number? ☐ Yes ☐ No	Phone 2: May we leave messages at this number? ☐ Yes ☐ No	
Email: May we email you information about our office? ☐ Yes ☐ No		
Emergency Contact (name and phone): Relationship to you:		
Who is your current Primary Care Doctor? What is the name and number of their clinic?		
Please list other health care professionals from whom you receive care (Name, specialty, phone):		
Insurance Company_____ ID #_____		
How did you find our office?		

WHAT ARE YOUR CURRENT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE.

1. 4.
2. 5.
3. 6.

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE INTERESTED IN:

Food Allergy Testing	Hormone Testing	Heavy Metal Testing
Nutritional Testing	Fertility Testing	Wellness Screening
Testing for Depression	Complete Cardiovascular Panel	Gynecologic & Breast Exam
Anxiety or Mental Health	Anti-aging/Preventive Medicine Testing	Digestive Analysis

Medical and Family History

Please list your current and past diagnoses (if any):
Please list past hospitalizations and surgical procedures (include date and hospital):
Have you been fully vaccinated? ☐ Yes ☐ No ☐ Unsure
List any known allergies to medications, foods or other substances as well as your reaction:
Have you traveled outside the United States in the past two years? ☐ Yes ☐ No. If yes, where?

Medications and Supplements

List all current medications, vitamins, herbs and other supplements you take, including dosages.

Medications:	Vitamins, Herbs, Other Supplements:

Family History

List any serious health conditions your family members have experienced. Include diabetes, heart disease, autoimmune disease, cancer, additions, eating disorders, mental disorders, allergies, genetic disorder or any other major concerns.

Condition:	Family Member:	Age of onset/age of death:

Social History and Lifestyle

Please list all persons and pets currently living with you:				
Habits	**Yes**	**No**	**Details**	
Current tobacco use	☐	☐	Packs per day:	
Past tobacco use	☐	☐	Packs per day:	When did you quit?
Alcohol consumption	☐	☐	How often? Types:	
Recreational drug use	☐	☐	Types:	
Exposure to toxic chemicals, solvents, other harmful toxins	☐	☐	If yes, please explain:	
Caffeine use (circle all): Coffee, tea, soda, energy drinks	☐	☐	Cups per day?	
Regular exercise	☐	☐	How often? Activities:	
Stress				
Current stress level: ☐ Low ☐ Medium ☐ High Source of stress: ☐ Job ☐ Financial ☐ Family/Relationship ☐ Other				
Sleep				
Problems falling asleep?	☐	☐	What keeps you awake?	
Problems staying asleep?	☐	☐		
Do you wake feeling refreshed?	☐	☐		
Do you snore or have sleep apnea?	☐	☐		
Nutrition				
Do you follow a particular diet?			Are there foods that you avoid eating? Why?	
How many meals do you typically eat in a day?			Where do you buy food? Who cooks the food you eat?	
Describe your typical breakfast: Lunch: Dinner: Snacks& Sweets: Drinks:				
Are you thirsty?	☐	☐	How much water do you drink a day:	
Mark any of the following that you consume regularly: ☐ Highly seasoned foods ☐ Processed foods ☐ Soda ☐ Candy				
List foods you crave:			List foods to which you have a reaction:	
Are you satisfied with your diet?	☐	☐	If no, why not?	

FEMALE HEALTH INFORMATION

DO HAVE A HISTORY OF ANY OF THE FOLLOWING:	Yes	No		Yes	No
Pelvic Inflammatory Disease	☐	☐	Fibroids	☐	☐
Chronic yeast or vaginal discharge	☐	☐	Urinary tract infections	☐	☐
Loss of bladder control	☐	☐	Breast cancer or benign tumors	☐	☐
Blood in urine	☐	☐	Painful urination	☐	☐
Chronic vaginal itching or burning	☐	☐	History or current STD If yes, which ones?	☐	☐

MENSTRUAL HISTORY

Date of last period:			Age at first period:
Did you have a normal puberty?	☐	☐	If no, why?
Are your periods currently regular?	☐	☐	Days between periods: Length of flow: Days of heavy bleeding: light: spotting:
Date of last PAP:			Date of last breast exam:
Were the results normal?	☐	☐	Date of last mammogram:
History of abnormal PAPs?	☐	☐	Abnormal findings:
Have you had your bone density checked?	☐	☐	If yes, when? Results:

MENSTRUATING WOMEN: Please mark any of the following symptoms you experience before (B), during (D) or after (A) your menstrual cycle. If you do not have a cycle, please mark symptoms you are currently experiencing.

B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom	B	D	A	Symptom
☐	☐	☐	Cramping or pain	☐	☐	☐	Headache	☐	☐	☐	Bloating	☐	☐	☐	Weight gain
☐	☐	☐	Constipation	☐	☐	☐	Breast tenderness	☐	☐	☐	Increased appetite	☐	☐	☐	Sweet cravings
☐	☐	☐	Depression	☐	☐	☐	Nervous tension	☐	☐	☐	Irritability	☐	☐	☐	Mood changes
☐	☐	☐	Forgetfulness	☐	☐	☐	Anxiety	☐	☐	☐	Confusion	☐	☐	☐	Crying
☐	☐	☐	Heart pounding	☐	☐	☐	Insomnia	☐	☐	☐	Fatigue	☐	☐	☐	Insomnia

Mother's age at menopause: Sister(s): Mother's age if she has not yet begun menopause:

MENOPAUSAL WOMEN: If you are currently peri-menopausal or menopausal, do you experience any of the following symptoms? Please indicate yes (Y), no (N) or past (P).

Y	N	P	Symptom	Y	N	P	Symptom	Y	N	P	Symptom	Y	N	P	Symptom
☐	☐	☐	Hot flashes	☐	☐	☐	Insomnia	☐	☐	☐	Vaginal dryness	☐	☐	☐	Memory loss
☐	☐	☐	Fatigue	☐	☐	☐	Decreased libido	☐	☐	☐	Weight gain	☐	☐	☐	Mood changes

OBSTETRIC HISTORY

Are you currently pregnant?	☐	☐		
Are you trying to conceive?	☐	☐		
Have you had problems with infertility?	☐	☐	if yes, please explain:	
Any pregnancy complications?	☐	☐	If yes, please explain:	
# of pregnancies: Births:			Miscarriages:	Abortions:
Are you currently breast feeding?	☐	☐	If yes, how often:	

SEXUAL HEALTH	Yes	No		Yes	No
Are you currently sexually active?	☐	☐	If yes, current contraception?		
Have you ever used birth control pills?	☐	☐	If yes, how long?		
Have you ever used and IUD?	☐	☐	If yes, how long and what kind?		
Are you content with your libido/sex life?	☐	☐	Any vaginal dryness or painful intercourse?	☐	☐
GASTROINTESTINAL HEALTH					
Number of bowel movements per day:			Is your stool loose or formed?		
Do you tend to constipation or diarrhea?			Stool have an unusual color or odor? If yes, explain:	☐	☐
Recent changes in bowel habits?	☐	☐	Any blood or mucous in stool?	☐	☐
Recent changes in appetite?	☐	☐	Any abdominal pain or upset stomach?	☐	☐
Any excessive gas or bloating?	☐	☐	Any heartburn? Or Reflux?	☐	☐
Any loss of bowel control?	☐	☐	Any nausea or vomiting?	☐	☐
Do you have hemorrhoids?	☐	☐	Have you had a colonoscopy? When?	☐	☐
Have you been diagnosed with IBS?	☐	☐	Do you have Inflammatory Bowel Disease?	☐	☐
WEIGHT HISTORY					
Are you content with your current weight?	☐	☐	If no, what is your ideal weight?		
Does your weight fluctuate?	☐	☐	If yes, give highs and lows:		
Any family history of weight problems?	☐	☐	If yes, who?		
What factors do you feel contribute to your changes in weight if any (nutrition, exercise, hormones, etc.)?					
EARS, EYES, NOSE AND THROAT					
Please indicate current(C) or past(P) symptoms	C	P		C	P
Loss of consciousness	☐	☐	Vertigo or dizziness	☐	☐
Loss of hearing	☐	☐	Ringing or buzzing in ears	☐	☐
Sinus problems	☐	☐	Loss of smell	☐	☐
Chronic congestion or nasal discharge	☐	☐	Ear infections	☐	☐
Frequent sore throats	☐	☐	Difficulty swallowing	☐	☐
Eye glasses or contacts	☐	☐	Loss of vision	☐	☐
Excessive tearing or dry eyes	☐	☐	Double or blurred vision	☐	☐
Light sensitivity	☐	☐	Sores in mouth, lips or gums	☐	☐
Tooth pain	☐	☐	Mercury fillings	☐	☐
RESPIRATORY HEALTH					
Chronic cough	☐	☐	Difficulty breathing	☐	☐
Bronchitis	☐	☐	Asthma or Emphysema	☐	☐
Tuberculosis or pneumonia	☐	☐	Date of last chest x-ray:		

CARDIOVASCULAR HEALTH					
Please indicate current(C) or past(P) symptoms	C	P		C	P
Chest pain	☐	☐	Heart palpitations	☐	☐
Heart murmur	☐	☐	Cold extremities	☐	☐
High or low blood pressure	☐	☐	Angina	☐	☐
Heart attack	☐	☐	Date of last ECG / EKG:		
MENTAL EMOTIONAL HEALTH					
Tension	☐	☐	Nervousness	☐	☐
Anxiety	☐	☐	Irritability	☐	☐
Depression	☐	☐	Inability to concentrate	☐	☐
Chronic procrastination	☐	☐	Eating disorder	☐	☐
ENDOCRINE HEALTH					
Fatigue	☐	☐	Heat or cold intolerance	☐	☐
Excessive hunger or thirst	☐	☐	Fever or excessive sweating	☐	☐
Hypoglycemia	☐	☐	Diabetes	☐	☐
Adrenal Fatigue	☐	☐	Thyroid conditions	☐	☐
Autoimmune disorder	☐	☐	Please Explain:		
MUSCULOSKELETAL HEALTH					
Chronic Headaches	☐	☐	If yes, how often?		
Numbness or tingling	☐	☐	If yes, where?		
Metal implants	☐	☐	If yes, where		

The above information is true to the best of my knowledge.

X_____ Date:_____

Signature of Patient or Person Legally Responsible

If you are interested in a **focused initial consultation only** and you would not like to discuss your health history, please complete the following:

I_____ understand that Dr. Kimberly Brown will not assess or address any extensive health issues. I am here solely on an acute care or informational visit. The doctor will not be responsible for anything we have not discussed. I understand I will need to make additional appointments to address any other health concerns.

X_____ Date:_____

Signature of Patient or Person Legally Responsible

Please use an X to indicate all areas you are experiencing pain or swelling: