

# Integrative Medicine Center

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NAME: \_\_\_\_\_

## Female Personal History Form

### Major Symptoms

What brings you in today (major complaint)? \_\_\_\_\_

How frequent and severe are your symptoms? \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_

How do your symptoms interfere with your daily life, family life, and career? \_\_\_\_\_

Treatment received so far:

What tests, medicines and consultations have been done so far? \_\_\_\_\_

Has this treatment helped? \_\_\_\_\_

Were there any complications with any previous treatments? \_\_\_\_\_

### Previous Medical History—Please check any conditions that apply to you

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Hypothyroidism                           | <input type="checkbox"/> Poor Sex Drive      | <input type="checkbox"/> Hypoglycemia             |
| <input type="checkbox"/> High Cholesterol                         | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Childhood onset     | <input type="checkbox"/> Adult onset              |
| Please give age of diagnosis. _____                               |  |   |
| <input type="checkbox"/> Arthritis Where are you affected? _____  |  |   |
| <input type="checkbox"/> Coronary artery disease or heart disease | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Macular Degeneration                     |  |   |
| <input type="checkbox"/> Other medical conditions: _____          |  |   |

### Surgical History—Please check any prior surgeries that apply to you

- |   |  |   |                       |
|---|--|---|-----------------------|
| <input type="checkbox"/> Adenoid removal      | <input type="checkbox"/> Sinus surgery     | <input type="checkbox"/> Tubes in ears    | How many times? _____ |
| <input type="checkbox"/> Gall Bladder removal | <input type="checkbox"/> Hysterectomy      | <input type="checkbox"/> Appendix removal |                       |
| <input type="checkbox"/> Ovaries removed      | <input type="checkbox"/> Joint replacement | Which joint? _____                        |                       |
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Other: _____      |   |                       |
| <input type="checkbox"/> Blood Type: _____    |  |   |                       |

### Medications/Supplements

Please list all prescriptions, over the counter medications, and supplements and dosages you are currently using. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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List all known allergies to food, drugs or environment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Social History:**

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Who lives at home besides you? \_\_\_\_\_

Are they healthy? \_\_\_\_\_

Number of children? \_\_\_\_\_ Do you or anyone at home smoke?  Yes  No

If yes, how many per day? \_\_\_\_\_ Do you have any animals?  Yes  No

If yes, what kind and how many do you have? \_\_\_\_\_

What is your job? \_\_\_\_\_

Has this or any other job put you around strong chemicals or smoke?  Yes  No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

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**Family Medical History**

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Please check the appropriate box for you and your family member if any of the following apply.

	<i>Self</i>	<i>Mother</i>	<i>Father</i>	<i>Grandparents</i>	<i>Siblings</i>	<i>Children</i>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list what type of cancer and what age it was found. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list other health concerns you may have: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Review of Systems: check all that apply**

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Head, Emotions, and Mind

- Headaches Where does it bother you? \_\_\_\_\_  
 Migraine Headaches How frequent? \_\_\_\_\_

- 
- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Anxiety                       | <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Depression                          | <input type="checkbox"/> Confusion     |
| <input type="checkbox"/> Poor sleep                    | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Reduction of memory                 | <input type="checkbox"/> Tremor        |
| <input type="checkbox"/> Numbness/tingling             |  | <input type="checkbox"/> Cannot think clearly—foggy thinking | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Loss of train of thought      |  | <input type="checkbox"/> Reduction in concentration          |  |
| <input type="checkbox"/> Obsessive/compulsive thoughts |  |  |  |
-

Present performance inferior to prior performance in level functioning (please explain): \_\_\_\_\_

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**Digestive Tract: check all that apply**

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- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Belching                       | <input type="checkbox"/> Nausea         |
| <input type="checkbox"/> Bad Breath          | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Bloating in the abdominal area |   |
| <input type="checkbox"/> Poor sense of taste | <input type="checkbox"/> Blood in stool        | <input type="checkbox"/> Hemorrhoids                    | <input type="checkbox"/> Sugar cravings |

**Energy-Activity**

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- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Get tired easily  | <input type="checkbox"/> Wake up tired | <input type="checkbox"/> Sleep excessively |
| <input type="checkbox"/> Feel cold at temperatures that other people are comfortable |  | <input type="checkbox"/> Weight gain       |
| <input type="checkbox"/> Muscular weakness or muscles tire easily                    |  | <input type="checkbox"/> Heat intolerance  |
| <input type="checkbox"/> Muscle cramps   |  |  |

**Skin: check all that apply**

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- |  |                                    |   |  |
|--|------------------------------------|---|--|
| <input type="checkbox"/> Cold hands                      | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Dry skin                             | <input type="checkbox"/> Hives         |
| <input type="checkbox"/> Psoriasis                       | <input type="checkbox"/> Acne      | <input type="checkbox"/> Loss of scalp hair                   | <input type="checkbox"/> rashes/eczema |
| <input type="checkbox"/> Facial puffiness in the morning |                                    | <input type="checkbox"/> Weak fingernails or fingernail lines |  |

**Cardiovascular: check all that apply**

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- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rapid heartbeat       | <input type="checkbox"/> Skipped heartbeat        |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Snore while sleeping  | <input type="checkbox"/> Fluid collection in feet |
| <input type="checkbox"/> Varicose veins      | <input type="checkbox"/> Mitral Valve Prolapse |   |

**Urinary tract/bladder: check all that apply**

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- |  |                       |   |
|--|-----------------------|---|
| <input type="checkbox"/> Kidney/bladder infections | Number of times _____ | <input type="checkbox"/> Burning upon urination |
| <input type="checkbox"/> Frequent urination        |                       | <input type="checkbox"/> Blood in urine         |
| <input type="checkbox"/> Awake at night to urinate |                       | <input type="checkbox"/> Incontinence           |

**Nose: check all that apply**

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- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Runny nose       |
| <input type="checkbox"/> Hay fever   | <input type="checkbox"/> Sinus infections |
- Number per year \_\_\_\_\_
- Have x-rays been done of the sinuses?  No  Yes If so, where? \_\_\_\_\_

**Lungs: check all that apply**

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- |   |                                 |   |   |
|---|---------------------------------|---|---|
| <input type="checkbox"/> Wheezing             | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis             | <input type="checkbox"/> Chest congestion |
| <input type="checkbox"/> Difficulty breathing |                                 | <input type="checkbox"/> Ever had a chest x-ray |   |

**Mouth, Throat and Ears: check all that apply**

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- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Sore throats   | How many per year? _____            | <input type="checkbox"/> Canker sores    |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Ringing in ears |

**Eyes: check all that apply**

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- |  |                                    |                                   |   |
|--|------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Watering or itching | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Macular degeneration |
|--|------------------------------------|-----------------------------------|---|
-

**Hormone Axis**

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- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Hot Flashes      | <input type="checkbox"/> Vaginal Dryness/Painful intercourse | <input type="checkbox"/> Weight gain in hips           |
| <input type="checkbox"/> Tired constantly | <input type="checkbox"/> Joint pain                          | <input type="checkbox"/> Cervical changes              |
| <input type="checkbox"/> Depressed        | <input type="checkbox"/> Continuous fatigue                  | <input type="checkbox"/> Mood swings                   |
| <input type="checkbox"/> Tearful          | <input type="checkbox"/> Doubt                               | <input type="checkbox"/> Gall Bladder disease          |
| <input type="checkbox"/> Night sweats     | <input type="checkbox"/> Incontinence                        | <input type="checkbox"/> Fibroids                      |
| <input type="checkbox"/> Fertility Issues | <input type="checkbox"/> Tender breasts                      | <input type="checkbox"/> Heavy and/or irregular menses |
| <input type="checkbox"/> Bone loss        | <input type="checkbox"/> Libido is low                       | <input type="checkbox"/> Nervous/irritable             |

**DHEA**

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- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Poor Noise Tolerance | <input type="checkbox"/> Lack of hair on arms or pelvic area | <input type="checkbox"/> Low libido   |
| <input type="checkbox"/> Belly fat            | <input type="checkbox"/> Flabby muscles                      | <input type="checkbox"/> Eyes are dry |

**Thyroid**

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- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cold hands                                       | <input type="checkbox"/> Cold feet        | <input type="checkbox"/> Dry skin             |
| <input type="checkbox"/> Dry, coarse brittle hair                         | <input type="checkbox"/> Facial puffiness | <input type="checkbox"/> Put on weight easily |
| <input type="checkbox"/> Feel more tired at rest than when you are active |   | <input type="checkbox"/> Hair loss            |
| <input type="checkbox"/> Hard time getting up in the morning              |   |   |

**Prog**

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- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Anxious, nervous                        | <input type="checkbox"/> Sleep light and restlessly | <input type="checkbox"/> Painful breasts               |
| <input type="checkbox"/> Premenstrual cramping, irritability, HA |   | <input type="checkbox"/> Symptoms worse in the evening |

**Cortisol**

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- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Get hives or skin rashes             | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Crave salt or sugar |
| <input type="checkbox"/> I am stressed out or easily confused |   |  |

**Specific Health Questions: Please answer/explain as completely as possible**

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How much caffeine do you drink a day? \_\_\_\_\_

How many diet drinks do you drink a day? \_\_\_\_\_

Have you ever had yeast infections? \_\_\_\_\_ How many? \_\_\_\_\_

Have you ever been on birth control or hormone replacement and how did you respond?  
\_\_\_\_\_

Have you had an abnormal Pap smear? \_\_\_\_\_

Do you crave or over consume sugar (sweets), chocolate, caffeine, or alcohol? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you skip caffeine, do you get caffeine withdrawal headaches?  Yes  No

In early childhood, did you experience: (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Frequent colds                     | <input type="checkbox"/> Frequent sore throats               | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Eczema                             | <input type="checkbox"/> Frequent sinus infections           | <input type="checkbox"/> Asthma                  |
| <input type="checkbox"/> Adverse reactions to immunizations | <input type="checkbox"/> Exposed to tobacco smoke, chemicals |  |

Multiple stays in the hospital \_\_\_\_ If yes, please give reason/s for hospital stays:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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In your teenage years to early adulthood, did you experience any of the above or:

- Hay fever                       Bladder/kidney infections                       Menstrual irregularities  
 Depression

Do any of the above symptoms continue currently? (please list and explain)

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**Preventative Care: please list date and family where test was completed**

Last mammogram: \_\_\_\_\_

Last pap smear: \_\_\_\_\_

Last bone density check: \_\_\_\_\_

Last colonoscopy: \_\_\_\_\_

Last cholesterol screen: \_\_\_\_\_

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