

# Female Health History Questionnaire

## GENERAL INFORMATION

**Winters Wellness Center Michael A. Winters, D.C.**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_ Best time/place to contact you \_\_\_\_\_  
 May we e-mail you office newsletters? Yes \_\_\_ No \_\_\_  
 SS# \_\_\_\_\_ Marital Status: Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Divorced \_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Occupation \_\_\_\_\_ Spouse/guardian name \_\_\_\_\_  
 Spouse's date of birth \_\_\_\_\_  
 Employer's name & address \_\_\_\_\_  
 Who may we thank for referring you? \_\_\_\_\_  
 Are you pregnant? Yes \_\_\_ No \_\_\_ Are you breastfeeding? Yes \_\_\_ No \_\_\_  
 Are you cyclic? Yes \_\_\_ No \_\_\_ Are you in Menopause? Yes \_\_\_ No \_\_\_

## COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptoms has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

## DAILY ACTIVITIES

Please list any daily activities which have been affected by the above conditions (examples: standing, sitting, bending, sports, anything at all)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes \_\_\_ No \_\_\_ If yes, please list.

\_\_\_\_\_

## SURGERY & ACCIDENT HISTORY

Have you had any surgery? (Please include all surgery)

1. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_
2. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_
3. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_
4. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_

Have you had any accidents and/or injuries: auto, work-related or other? (Especially those related to your present problems).

1. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_
2. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_
3. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_
4. Type: \_\_\_\_\_ When? \_\_\_\_\_ Hospitalized? Yes \_\_\_ No \_\_\_

## ALLERGIES

Medication/Supplement/Food	Reaction

## DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes \_\_\_ No \_\_\_ If yes, how many? \_\_\_\_\_

If yes, please list which kinds. \_\_\_\_\_

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

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes \_\_\_ No \_\_\_

Have you had any dental work done in the last 12 months? Yes \_\_\_ No \_\_\_

## MEDICATIONS & SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs

Medication Name	Dosage

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems? Yes \_\_\_\_\_  
No \_\_\_\_\_ If yes, please describe \_\_\_\_\_

## SLEEP/REST

>10     8 – 10     6 – 8     <6

Average number of hours you sleep

Do you have trouble falling asleep? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you feel rested upon awakening? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have problems with insomnia? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you snore? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you use sleeping aids? Yes \_\_\_\_\_ No \_\_\_\_\_ Explain: \_\_\_\_\_

## LIFESTYLE INDICATORS

### TOBACCO HISTORY

Currently using tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_ How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

If yes, what type? Cigarette \_\_\_\_\_ Smokeless \_\_\_\_\_ Cigar \_\_\_\_\_ Pipe \_\_\_\_\_ Patch/Gum \_\_\_\_\_

Previous smoking: How many years? \_\_\_\_\_ Packs per day: \_\_\_\_\_

Are you exposed to 2<sup>nd</sup> hand smoke? If yes, please explain: \_\_\_\_\_

### ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None \_\_\_\_\_ 1-3 \_\_\_\_\_ 4-6 \_\_\_\_\_ 7-10 \_\_\_\_\_ >10 \_\_\_\_\_

Previous alcohol intake? Yes \_\_\_\_\_ (Mild \_\_\_\_\_ Moderate \_\_\_\_\_ High \_\_\_\_\_)

### CAFFEINE INTAKE

How many cups of coffee per day? None \_\_\_\_\_ 1-3 \_\_\_\_\_ 4-6 \_\_\_\_\_ 7-10 \_\_\_\_\_

How many cans of soda per day? None \_\_\_\_\_ 1-3 \_\_\_\_\_ 4-6 \_\_\_\_\_ 7-10 \_\_\_\_\_

Is the soda you drink, diet soda? Yes \_\_\_\_\_ No \_\_\_\_\_

## PREGNANCY HISTORY

Check box if yes and provide number of

Pregnancies \_\_\_\_\_     Caesarean \_\_\_\_\_     Vaginal deliveries \_\_\_\_\_

Miscarriage \_\_\_\_\_     Abortion \_\_\_\_\_     Living children \_\_\_\_\_

Post partum depression \_\_\_\_\_     Toxemia \_\_\_\_\_     Gestational diabetes \_\_\_\_\_

Baby over 8 pounds     Breast feeding - for how long? \_\_\_\_\_

## FOR THE CYCLIC-AGE WOMAN

Age at 1<sup>st</sup> period: \_\_\_\_\_ Menses Frequency: \_\_\_\_\_ Length of period: \_\_\_\_\_ Pain: Yes \_\_\_ No \_\_\_  
Clotting: Yes \_\_\_ No \_\_\_ Has your period skipped? \_\_\_\_\_ For how long? \_\_\_\_\_  
Last Menstrual Period: \_\_\_\_\_ How many days is your current cycle?  
Do you currently use contraception? Yes \_\_\_ No \_\_\_ If yes, what type do you use?  
 Condom  Diaphragm  IUD  Partner vasectomy  
Have you ever used hormonal contraception? Yes \_\_\_ No \_\_\_ If yes, when \_\_\_\_\_  
Use of hormonal contraception:  Birth control pills  Patch/Injection  Nuva Ring  
Are you using the pill now? Yes \_\_\_ No \_\_\_ Did taking the pill agree with you? Yes \_\_\_ No \_\_\_  
In the 2<sup>nd</sup> half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)?  Yes  No  
Date of last Mammogram \_\_\_\_\_ Breast Biopsy/Date \_\_\_\_\_  
Last PAP Test: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_  
Other information for us to know: \_\_\_\_\_

## FOR THE WOMAN IN MENOPAUSE

Age at onset of menopause: \_\_\_\_\_ Year of onset of menopause: \_\_\_\_\_  
When you were cycling, would you consider your cycle regular? Yes \_\_\_ No \_\_\_  
If no, why? \_\_\_\_\_  
When you were cycling, what was your typical menstrual flow? Light \_\_\_ Medium \_\_\_ Heavy \_\_\_  
Have you had a hysterectomy? Complete (ovaries and uterus) \_\_\_\_\_ Partial (uterus only) \_\_\_\_\_  
Date of hysterectomy \_\_\_\_\_ Reason for hysterectomy: \_\_\_\_\_  
Date of last Mammogram \_\_\_\_\_ Breast Biopsy/Date \_\_\_\_\_  
Date of last Bone Density \_\_\_\_\_ Results:  High  Low  Within normal range  
Are you in menopause? Yes \_\_\_ No \_\_\_ Age at Menopause \_\_\_\_\_  
Do you take:  Estrogen  Ogen  Estrace  Premarin  Progesterone  
 Provera  Other \_\_\_\_\_  
How long have you been on hormone replacement? \_\_\_\_\_  
Other information for us to know: \_\_\_\_\_