Female Intake Form

Julia Greenspan, ND

Patient Note: This is a confidential record of your medical history. It will not be released except with your authorization. Please complete this questionnaire as thoroughly as possible. Mark anything you do not understand with a question mark.

If mailing please return to **P.O. Box 985, Hollis, New Hampshire 03049**

Date ________________ Social Security Number _______________________________

Name ____
Last First MI

Address ___________________________________ Date of Birth ________________________

___________________________________ Age ________________________

Phone ___________________________ ▫ It's ok to leave message about my care

Email ____

Occupation ____

Employment Status: Full-time Part-time Student Retired Unemployed
Please circle: Married Divorced Single Widowed Significant Partnership
Live with: Spouse Partner Relatives Friends Alone Pets

Emergency Contact Person ____________________________ Relation_____________
Address____ Phone_____________________

How did you hear about GreeNHouse Naturopathic Medicine:
Referral/Friend _________________________________
Yellow pages Lecture Walk or Drive-by Article Internet

Would you like to receive our quarterly newsletter by email? Y N

What are your main health concerns?

1. ____
2. ____
3. ____
4. ____

Financial Agreement
I claim full financial responsibility for services rendered by GreeNHouse Naturopathic Medicine and understand payment is required at the time of service.

____ ________________________
Signature *Date*

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Opinions About Your Health

How does your condition affect you?

What do you think is happening; why do you think you have this condition?

What do you feel needs to happen for you to get better?

How much change are you willing to make at this time for improving your health?

circle one: MINIMAL SOME COMPLETE

Allergies

To any drugs?

To any foods?

To any environmental pollens/grasses?

Other?

Past Medical History

Surgeries: List the type and year of any surgeries:

Hospitalizations: List any other hospitalizations and the reason:

List all the **medications** that you are currently taking, including dosages:

List all **vitamins, minerals, herbs, homeopathic remedies and nutritional supplements** you are currently taking:

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Personal Habits

Do you eat three meals per day? Y N

Do you wake feeling rested? Y N

Do you have a supportive relationship? Y N

Have you had any major traumas? Y N

Do you have a history of abuse? Y N (physical, emotional or sexual)

Do you drink coffee? Y N

Do you drink sodas or energy drinks? Y N

Do you consume alcohol? Y N (Beer Wine Spirits)

Number of drinks per day/week/month _______

Do you smoke? Y N Current or Past Yr started _______ Yr stopped __________
Do you now or have you ever used recreational drugs? Y N
Do you have a religious or spiritual practice? Y N Do you enjoy your job? Y N

Do you watch TV? Y N hrs per week_____ Do you read? Y N hrs per week____

Sleep
Usual bedtime _______ Hours slept_______
Problems with falling asleep? Y N Waking up after your fall asleep? Y N
Dreams and/or nightmares: Y N

Energy Level when waking up, throughout the day. (1 = low, 10 = high)
1 2 3 4 5 6 7 8 9 10

Exercise
How often do you exercise and what type of exercise?

Do you experience any symptoms during exercise (pain in any particular place in your body, shortness of breath, extreme fatigue beyond what is normal for the activity, heart palpitations, dizziness, abnormally high or low perspiration, etc.)?

Current Health Status and History

What is your blood type? _________________
Weight ___________ Weight 1 year ago ____________
Maximum Weight _________ when?
What do you think should be your desired weight ____________ Height ___________

*Please circle any of the following conditions/symptoms you have had, **Yes**-I have this now; **Never**-I've never had it; **Past**-I've had it in the past but not now.*

Head

Headaches	Y	N	P	Migraines	Y	N	P
Lightheadedness	Y	N	P	Dizziness	Y	N	P
Bell's Palsy	Y	N	P	Head injury or trauma	Y	N	P
Concussion	Y	N	P	Loss of balance	Y	N	P
Jaw/TMJ problems	Y	N	P	Other? ________________________________			

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Eyes

Spots in eyes	Y	N	P	Impaired vision	Y	N	P
Blurriness	Y	N	P	Color blindness	Y	N	P
Double vision	Y	N	P	Eye pain	Y	N	P
Swollen eyes	Y	N	P	Eyestrain	Y	N	P
Cataracts	Y	N	P	Glasses/contacts	Y	N	P
Tearing or dryness	Y	N	P	Glaucoma	Y	N	P
Night blindness	Y	N	P	Circles under eyes	Y	N	P

Other ___________________________________

Ears

Impaired hearing	Y	N	P	Deafness	Y	N	P
Earaches	Y	N	P	Itching of ears	Y	N	P
Ringing in ears	Y	N	P	Excessive ear wax	Y	N	P
Frequent ear infections	Y	N	P				

Other? ___________________________________

Nose & Sinuses

Frequent colds	Y	N	P	Stuffiness	Y	N	P
Post nasal drips	Y	N	P	Loss of Smell	Y	N	P
Nose bleeds	Y	N	P	Sinus Problems	Y	N	P
Hayfever	Y	N	P	Allergies	Y	N	P
Polyps	Y	N	P	Other? ___________________________			

Mouth & Throat

Frequent sore throat	Y	N	P	Sores in mouth	Y	N	P
Hoarseness	Y	N	P	Difficulty swallowing	Y	N	P
Loss of taste	Y	N	P	Teeth grinding	Y	N	P
Sore lips	Y	N	P	Enlarged lymph nodes	Y	N	P
Sore tongue	Y	N	P	Gum problems	Y	N	P
Dental problems	Y	N	P	Difficulty speaking	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P
Copious saliva	Y	N	P	Dry mouth	Y	N	P

Other? ___________________________________

Respiratory

Coughing	Y	N	P	Spitting up blood	Y	N	P
Wheezing	Y	N	P	Difficulty breathing	Y	N	P
Pain with breathing	Y	N	P				
Shortness of breath	Y	N	P	while lying down?	at night?		
Sputum	Y	N	P	Bronchitis	Y	N	P
Pleurisy	Y	N	P	Emphysema	Y	N	P
Pneumonia	Y	N	P	Asthma	Y	N	P
Positive TB Test	Y	N	P	Other? ___________________________			

Cardiovascular

Heart disease	Y	N	P	High/Low blood pressure	Y	N	P
Blood Clots	Y	N	P	Phlebitis	Y	N	P
Rheumatic Fever	Y	N	P	Swelling in ankles	Y	N	P
Bleeding/clotting disorder	Y	N	P	High cholesterol	Y	N	P
Atherosclerosis	Y	N	P	Angina	Y	N	P
Heart murmurs	Y	N	P	Fainting	Y	N	P
Palpitations	Y	N	P	Heart Flutters	Y	N	P
Chest Pain	Y	N	P	Stroke	Y	N	P
Heart attack	Y	N	P	Other? ___________________________			

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Circulation

Cold hands/feet	Y	N	P	Deep leg pain	Y	N	P
Easy bleeding/bruising	Y	N	P	Varicose veins	Y	N	P
Thrombophlebitis	Y	N	P	Other? ______________________			

Gastrointestinal

Trouble swallowing	Y	N	P	Jaundice	Y	N	P
Nausea	Y	N	P	Vomiting blood	Y	N	P
Blood in stool	Y	N	P	Abdominal pain/cramps	Y	N	P
Belching or passing gas	Y	N	P	Gallbladder disease	Y	N	P
Ulcers	Y	N	P	Liver disease	Y	N	P
Hepatitis	Y	N	P	Heartburn	Y	N	P
Acid Reflux	Y	N	P	Change in appetite	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P
Bloating	Y	N	P	Stomach pain	Y	N	P
Black Stools	Y	N	P	Diverticulitis/losis	Y	N	P
Crohn's disease	Y	N	P	Irritable Bowel Syndrome	Y	N	P
Hemorrhoids	Y	N	P	Change in thirst	Y	N	P
Colitis	Y	N	P	Hiatal Hernia	Y	N	P
Vomiting	Y	N	P	Other? ______________________			

Frequency of bowel movements (number per day) ______________________

Quality of stools (small and hard, loose, etc.) ______________________

Urinary

Pain during urination	Y	N	P	Frequency at night	Y	N	P
Bladder infections	Y	N	P	Unable to urinate	Y	N	P
Increased frequency	Y	N	P	Unable to hold urine	Y	N	P
Kidney stones	Y	N	P	Blood in urine	Y	N	P

Other? ______________ Approximate number of times you urinate per day________

Waking up at night to urinate: Y N Pain or other symptoms during urination, etc. Y N

Skin

Rashes	Y	N	P	Hives	Y	N	P
Acne, boils	Y	N	P	Moles	Y	N	P
Lumps	Y	N	P	Ulceration	Y	N	P
Shingles	Y	N	P	High cholesterol	Y	N	P
Atherosclerosis	Y	N	P	Eczema	Y	N	P
Psoriasis	Y	N	P	Itching	Y	N	P
Dryness	Y	N	P	Perpetual hair loss	Y	N	P
Night sweats	Y	N	P	Sores	Y	N	P
Infections	Y	N	P	Change in hair/nails	Y	N	P

Other? ______________________

Neck

Pain or stiffness	Y	N	P	Swollen Glands	Y	N	P
Pinched nerve	Y	N	P	Lumps	Y	N	P
Herniated disk	Y	N	P	Other? ______________________			

Musculoskeletal

Joint pain or stiffness	Y	N	P	Muscle spasms	Y	N	P
Muscle weakness	Y	N	P	Arthritis	Y	N	P
Bursitis	Y	N	P	Osteoporosis	Y	N	P
Osteopenia	Y	N	P	Broken Bones	Y	N	P
Back Pain	Y	N	P	Herniated disk	Y	N	P
Back surgery	Y	N	P	Other? ______________________			

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Neurological

Seizures	Y	N	P	Muscle weakness	Y	N	P
Loss of memory	Y	N	P	Vertigo	Y	N	P
Dizziness	Y	N	P	Trembling hands/feet	Y	N	P
Mood swings	Y	N	P	Epilepsy	Y	N	P
Paralysis	Y	N	P	Numbness or tingling	Y	N	P
Loss of balance	Y	N	P	Lightheaded	Y	N	P
Poor concentration	Y	N	P	Slurred speech	Y	N	P
Neuralgia	Y	N	P	Loss of coordination	Y	N	P
Easily stressed	Y	N	P	Other? ______________________________			

Mental / Emotional

Excess Stress	Y	N	P	Anxiety	Y	N	P
Panic Attacks	Y	N	P	Depression	Y	N	P
Mood swings	Y	N	P	Memory loss	Y	N	P
Suicidal thoughts	Y	N	P	Treated for emotions	Y	N	P
Nervousness	Y	N	P	Seasonal depression	Y	N	P

Other? ________________________________

Endocrine

Hypothyroid	Y	N	P	Hyperthyroid	Y	N	P
Hypoglycemia	Y	N	P	Excessive thirst	Y	N	P
Unexplained weight loss	Y	N	P	Fatigue	Y	N	P
Hormonal problems	Y	N	P	Heat or cold intolerance	Y	N	P
Diabetes	Y	N	P	Excessive hunger	Y	N	P
Seasonal depression	Y	N	P	Easy weight gain	Y	N	P
Pituitary disorder	Y	N	P	Adrenal problem	Y	N	P

Other? ______________________________

Immune

Slow wound healing	Y	N	P	Chronic fatigue syndrome	Y	N	P
Chronic swollen glands	Y	N	P	Reaction to vaccinations	Y	N	P
Chronic infections	Y	N	P	Cancer	Y	N	P

Other? _________________________

Infectious Illnesses

Scarlet Fever	Y	N	P	Diphtheria	Y	N	P
Rheumatic Fever	Y	N	P	Chicken Pox	Y	N	P
German Measles	Y	N	P	Mumps	Y	N	P
Measles	Y	N	P	Polio	Y	N	P
Meningitis	Y	N	P	Epstein-Barr	Y	N	P
Tick Bite	Y	N	P	Other? ________________________________			

Female Reproductive History

Menstruation

Your age when you had your first menstrual period? _____ Are you past menopause? Y N

What was the date of the **start** of your most recent menstrual period?_______________

How long do your periods last?___________ Are your cycles regular? Y N

How long is your cycle (from the start of one period to the start of the next)? ___________

Do you use pads or tampons?____________ How many on heaviest day?____________

Do you experience cramps, pain or other symptoms **during your period**? ____________

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Pre-Menstrual Symptoms

Do you experience any of the following **prior to your menstrual period**?

Breast Tenderness	Y N	Bloating Skin	Y N	Problems	Y N
Mood	Y N	Changes	Y N	Headache	Y N
Cramping	Y N	Diarrhea	Y N	Appétit Changes	Y N
Low Back Pain	Y N	Constipation	Y N	Discharge (breast, vaginal)	Y N

Do any of the above symptoms improve with the start of your flow?

Gynecological Conditions

Have you ever had recurring bladder or vaginal infections? Y N

Have you ever had gynecological or breast surgery (including breast augmentation)?

Current problems or past history of sexually transmitted disease/s?

Date of your last PAP? ______________ Ever had an abnormal PAP?___________

Date of last mammogram?____________

Have you ever had any of the following conditions?

breasts: ____ discharge ____ tenderness ____ swelling ____ lumps ____ fibrocystic

____ polycystic ovary disease ____ uterine fibroids ____ cervical cancer

Sexual History

Are you currently sexually active?_____ Do you have multiple partners? ________

If yes, with men, women or both? _____

Do you experience pain or discomfort during sex? _______

Birth Control

___ none past present ___ hysterectomy ___ IUD past present ___ Tubal ligation

___ Diaphragm past present ___ oral contraceptive ___________________________

___ condoms past present ___ patch / implant ____________________________

___ partner vasectomy past present ___ other _____________________________

Pregnancy History

Times pregnant ____ Live births ____ Miscarriages ____ Abortions ____ Premature births____

Pg #	DOB	Birth Weight	gender	Length of pregnancy	Delivery type	Breast fed?	Complications
1							
2							
3							
4							
5							

Childhood History

To the best of your memory, please provide the following information about YOUR childhood

Age of your mother when you were born: ______

Number of her previous pregnancies:_______

Indicate any medical problems your mother had while pregnant with you?

Did your mother take any medications during pregnancy?

Did she use Alcohol or Tobacco while pregnant with you or while nursing? Y N

Were you breastfed as a child and if so, how long?

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Did your parents note any adverse reactions to vaccinations or illnesses around the time you received them?

During each of the following age periods, 1) where did you live, 2) what illnesses did you have?
- birth to 2 years

- 2 years to 5 years

- 5 years to puberty

- puberty through roughly age 20

Family Medical History

	Mother	**Father**	**Brothers**		**Sisters**		**Children**	
Age (if living)								
Cancer								
Diabetes								
Heart Trouble								
High Blood Pressure								
Stroke								
Epilepsy								
Mental disorders								
Asthma								
Allergies								
Other conditions								
Age of Death								
Cause of Death								