

Tell us about any significant family health history:

Mother: _____
Father: _____
Grandparents: _____
Siblings: _____
Aunts/Uncles: _____

Do you have any allergies to food, medicine or environment?

Please list your medications, with dosages

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Please list any supplements, herbs or over the counter medications

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When was your last physical exam?

When was your last colonoscopy?

Men: When was your last PSA?

Women: (circle one) Menstruating?

Irregular Menstruation?

Menopausal?

Date of last period:

Date of hysterectomy (if applicable):

Date of last mammogram:

Date of last pap smear:

Your Lifestyle Profile

Do you smoke? Did you ever smoke? Packs/day: Years:

Do you exercise? Type: Times per week:

Are you under new stress? How many alcoholic drinks per week on average?

Diet: Typical breakfast:

Typical lunch:

Typical dinner:

Typical snacks:

What do you do for work?

Sleep: How many hours of sleep do you get at night?

Do you have difficulty falling asleep or staying asleep?

Do you snore? Do you wake up rested?

Do you yawn throughout the day? Do you wake up with a headache?

Gut Health: Do you have any gut issues? Bloating, constipation, nausea, abdominal pain, diarrhea, food intolerances?
Please explain: _____

LOW ESTROGEN? (women only)

Please place a check mark next to symptoms you are experiencing:

| | |
|------------------------|-----------------|
| Hot flashes: | Night Sweats: |
| Vaginal dryness: | Foggy thinking: |
| Scanty or no menses: | Depressed: |
| Bone loss/ osteopenia: | Tearful: |
| Memory difficulties: | Hair loss: |

HIGH ESTROGEN?

| | |
|--------------------|--|
| Breast tenderness: | Fibrocystic breasts (dense): |
| Fibrosis: | Heavy hips or abdomen? |
| PMS: | Water retention |
| Endometriosis: | Breast or prostate enlargement (male): |
| Heavy Periods: | |

LOW PROGESTERONE?

| | |
|-----------------------|----------------|
| PMS: | Irritable: |
| Miscarriages: | Insomnia: |
| Irregular periods: | Migraines: |
| Heavy periods: | Fibroids: |
| Clots with periods: | Infertility: |
| Breast tenderness: | Endometriosis: |
| Bone loss/osteopenia: | |

HIGH PROGESTERONE? (women only)

| | |
|---------|---------------|
| Sleepy: | Nausea: |
| Dizzy: | Night Sweats: |

LOW TESTOSTERONE/DHEA?

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|-------------------------------|-----------------------------------|
| Low sex drive: | Joint aches and pains: |
| Weak muscles/low muscle tone: | Masculine hair loss pattern: |
| Low energy: | Reduce sexual performance (male): |
| Bone loss/osteopenia: | |

HIGH TESTOSTERONE / DHEA?

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|-------------------------|-----------------------|
| High sex drive: | Nightmares: |
| High energy: | Facial hair (women): |
| Masculine hair pattern: | Sore nipples (women): |
| Good mental focus: | Acne: |
| Good physical stamina: | |

LOW THYROID?

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|-------------------------|------------------------|
| Low body temperature: | Depressed or low mood: |
| Slow or foggy thinking: | Low energy: |
| Loss of outer eyebrows: | Hair loss: |
| Sensitive to cold: | Sleeping more: |
| Easy weight gain: | Infertility: |
| Constipation: | Puffy around the eyes: |

HIGH THYROID?

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|--|-----------------------|
| Fast heart rate/ butterflies in chest: | Nervous/anxious: |
| Diarrhea or loose stools: | Sensitive to heat: |
| Weight loss/inability to gain weight: | Increased appetite: |
| Tremors/shakiness: | Increase in eye size: |

LOW CORTISOL / ADRENAL FUNCTION?

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|-------------------------------------|----------------------------|
| Easily startled: | Many allergies: |
| Low emotional reserve: | Sensitive to bright light: |
| Low blood pressure: | Crave caffeine: |
| Dizzy on rising: | Low blood sugar: |
| Can't tolerate hot or cold weather: | Anxious / fearful: |
| Fatigue/ tires easily: | Leg hair loss: |

HIGH CORTISOL / ADRENAL FUNCTION?

| | |
|--|--------------------------------------|
| Difficulty falling asleep or staying asleep: | Depressed: |
| Easy weight gain: | Elevated blood pressure: |
| Apple body shape: | Hair growth on face or body (women): |
| Easily craves sugar: | Anxious: |

Anything else that we missed?
