Female Health History Questionnaire

(To be completed by patient)

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation.

Name:____ Date:_________________

Current Health Status/Concerns

Please provide us with current and ongoing problems

Concern	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	**May 2006**	**2 times per week**	**Acupuncture/Aspirin**	**Mild improvement**

What diagnosis or explanation(s), if any, have been given to you for these concerns?

____

____

____

When was the last time that you felt well?____

What seems to trigger your symptoms?____

What seems to worsen your symptoms?____

What seems to make you feel better?____

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What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?____

____

____

____

How much time have you lost from work or school in the past year due to these conditions?___________

____

Past Medical & Surgical History

If you have experienced a reoccurrence of an illness, please indicate when or how often under comments.

Illnesses	When /Onset	Comments
Anemia		
Arthritis		
Asthma		
C-Dif		
Cancer (specify type)		
Chicken Pox		
Chronic bacteria or fungal infections		
Cycling Disorder (PCOS, endometriosis, fibroids)		
COVID		
Crohn's Disease or Ulcerative Colitis		
Diabetes (all Types)		
Emphysema, COPD		
Epilepsy, convulsions, or seizures		
Gallstones		
Gout		
Heart Attack, Angina		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Influenza		
IBS (or chronic diarrhea/constipation)		

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Kidney stones		
Lyme		
Measle, Mumps, Rubella		
Mental Health Issue (OCD, ADD etc.)		
Mononucleosis or EBV		
Parasite Infection		
Pneumonia		
SIBO/SIFO		
Sleep Apnea		
Stroke (specify type)		
Thyroid disease (Including Graves and Hashimoto's)		
Other (describe)		

Injuries	When	Comments
Back injury		
Broken bones or fractures (describe)		
Head injury or Concussion		
Neck injury		
Other (describe)		

Diagnostic Studies	When	Comments
Biopsy (specify location)		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Endoscopy		
Liver Scan		
Mammogram		
MRI		
Thermography		
X-Ray (Please indicate type)		
Other (describe)		

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Surgeries	When	Comments
Ablation		
Appendectomy		
Breast Explant (Removal of implants)		
Breast Implant		
Gall Bladder		
Gender Reassignment Surgery		
Hernia		
Hysterectomy		
Mastectomy		
Tonsillectomy		
Tubal Ligation		
Tubes in Ears		
Other (describe)		

Hospitalizations

Where Hospitalized	When	Reason

Medications

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc.)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

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Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?
Yes___ No ___
If yes, please list:____

____

Childhood History

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full-term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

Immunization History

Please indicate if you have been vaccinated against any of the following diseases:	Yes	No	Don't Know	Comment (Any know adverse reactions)
Smallpox				
DTaP (Diphtheria, Tetanus, Pertussis)				
Polio (oral or injected)				
Hepatitis (specify type)				
MMR (Mumps, Measles, Rubella)				
Typhoid				
Cholera				
Shingles				
Influenza (Flu Shot)				
RSV				
HPV				
COVID (specify number of doses and maker)				

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Childhood Diet

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc.)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea)____

____

Childhood Illnesses

Please indicate which of the following problems/conditions you experienced as a child (**ages birth to 12 years**) and the approximate age of onset.

	YES	AGE
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		

	YES	AGE
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g. dermatitis)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		
Measles		
Other:		

As a child did you: Have a high absence from school? Yes___ No___

If yes, why?____

Experience chronic exposure to second hand smoke in your home? Yes___ No___
Experience abuse Yes___ No___ Have alcoholic parents? Yes___ No___

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Female Medical History

(to be completed by all women)

Age at onset of first period: ___________

What are you using for contraception at the moment? ____

Have you ever used ***oral, injected, patch, or ring*** hormone contraceptives, or used *Emergency Contraception ("the morning after" or Plan B pill)?* Yes___ No___

From _______________to________________

Did you suffer from any side effects? Yes___ No___ Explain:_____________________________________

Are you currently or have you ever used an IUD? Yes___ No____
When? ____________________________ For how long? ________________________________

While using any and all birth control methods, did you experience the following?
Yeast - Heavy/Light bleeding - Mood - Weight gain - Acne
Sweet cravings - Fatigue - Depression - Palpitations, etc.

(Please circle and use extra space provided if explanation is needed)

____
____
____

Are you currently, or have you ever used fertility treatment? Yes___ No___
If yes, please explain. ____
____

Do you have any history of abnormal Pap Tests? Yes___ No___
If yes, please explain: ____

Please describe any treatment and/or medication for this: ____________________________________

Do you have any history of vaginal infections? Yes___ No___
If yes, please describe: ____

Please describe any treatment and/or medication for this: ___________________________________

Do you have any history of the following conditions? **(*Please circle appropriate answer)***

Ovarian Cysts - Fibrocystic Breasts - Polycystic Ovarian Syndrome (PCOS)
Uterine Fibroids - Endometriosis - Lichen Sclerosis - Vulvodynia

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Diagnostic Testing

Last PAP test: _____/_____/______ Normal:____________Abnormal:___________

Last Mammogram:_____/_____/_____ Breast biopsy? Date:_____/_____/______

Breast Thermography: _____/_____/______

Date of last bone density:_____/_____/______ Results: High____ Low____ Within normal range___

Pregnancy History

(to be completed by all women, if applicable)

Have you been pregnant before? Yes___ No___

Please list the age(s) of your children: ____

Please explain important details/complications below:

Number of pregnancies: ______ ____

Number of live births: ______ ____

Number of miscarriages: ______ ____

How many weeks gestation at the time of miscarry? _____ Weeks

Number of premature births: ______ ____

Number of cesarean births: ______ ____

Number of stillbirths: ______ ____

Number of ectopic pregnancies: ______ ____

Number of terminated pregnancies: ______ ____

Cycling History

(to be completed by all women who have not reached menopause)

What was the first date of your last menstrual period (LMP)? ______________________________

Have you ever had tubal ligation surgery? Yes___ No___

If so, please list the date and specific details: ____

____

Counting from the first day of your cycle to the first day of your next cycle, how many days is your current cycle? *(Please circle appropriate answer)*

<20 days 20-30 days 30-40 days 40-50 days >50 days

What is the length of days your menstruation typically lasts? ____________

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Do you consider your cycle to be regular? Yes___ No___ Not Always___

Details: ____

What is your typical menstrual flow like? Light Medium Heavy

Details: ____

How many pads and/or tampons *(circle)* do you use on heavy days? __________

During menstruation, do you pass blood clots? Yes___ No___

How often? _________________

How would you describe your cramping? None Mild Moderate Severe

At what point in your cycle? ____

Have you noticed any recent changes to your cycle? If yes, explain: ______________________

Do you experience any unusual or excessive vaginal discharge throughout the month?

Yes___ No___ When? ____________________________

Do you ever experience itching or odor in the vaginal area? Yes___ No___

When? ____________________________

Do you experience any breast tenderness? None Mild Moderate Severe

If yes, at what point in your cycle? ____

Do you have nipple discharge at any point in your cycle? Yes___ No___

If yes, at what point in your cycle? ___________________________ Color? ____________________

Menopausal Women

(Menopause is reached after 1 full year without a menstrual cycle or after a hysterectomy)

What age were you at the onset of menopause? __________ Year of onset? _________

Date of your last menstrual period? _________________

Please describe any recent changes and/or symptoms associated with your cycle prior to menopause:____

____

____

____

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Please list any and all GYN surgeries: What was the reason for each surgery?

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

Please give an in-depth explanation of how you perceive your experience transitioning into menopause: *(for example, please list symptoms, emotional changes, thoughts, stressors, etc.)*

____
____
____

Are you currently, or have you ever used any alternative, complementary, or natural remedies to treat your menopause? Yes___ No___

If yes, please list the name(s) of each product: ____________________________

What is/was the dosage? ______________ For how long? ____________________

Do you currently, or have you, at any point since beginning menopause experienced vaginal spotting or bleeding? Yes___ No___

If yes, what? ____

Treatment: ____

Below please describe your cycle history.

Would you have described your menstruation as: Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light Medium Heavy

When you were cycling would you describe your cycle as regular? Yes___ No___

If no, please give explanation: ____

____

In the past, if you have ever received any type of "treatment" for any cycle issues would you please explain: ____

____
____

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Family Health History

Please indicate current and past family history to the best of your knowledge

Check Family Members that Apply	**Father**	**Mother**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									

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Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Substance abuse (such as alcoholism)									
Ulcers									

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Dental History

	Yes	No
Problem with sore gums (gingivitis)?	______	______
Ringing in the ears (tinnitus)?	______	______
Have TMJ (temporal mandibular joint) problems?	______	______
Metallic taste in mouth?	______	______
Problems with bad breath (halitosis) or white tongue (thrush)?	______	______
Previously or currently wear braces?	______	______
Problems chewing?	______	______
Floss regularly?	______	______
Do you have amalgam dental fillings? How many?	______	______
Did you receive these fillings as a child?	______	______

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

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Nutritional History

Have you made any changes in your eating habits because of your health? Yes____ No_____

If yes, when did you make these changes? ____

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc.)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? Yes____ No_____

- ❑ Ovo-lacto
- ❑ Diabetic
- ❑ Dairy restricted
- ❑ Vegetarian
- ❑ Vegan
- ❑ Blood type diet
- ❑ Other (describe)____

Please tell us if there is anything special about your diet that we should know.______________________

____

Do you have symptoms ***immediately after*** eating, such as belching, bloating, sneezing, hives, etc.?
Yes___ No____
If yes, are these symptoms associated with any particular food or supplement? Yes___ No____
If yes, please name the food or supplement and symptom(s). ___________________________________

____

Do you feel that you have ***delayed*** symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc.? (symptoms may not be evident for 24 hours or more)
Yes___ No____

Do you feel **worse** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other_______________________

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Do you feel **better** when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other________________________

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes _____ No _____ If yes, what food(s) ____

____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) ____

____

Please complete the following chart as it relates to your bowel movements:

Frequency	√	Color	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose			

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Lifestyle History

Tobacco History

Have you ever used tobacco? Yes ____ No _____

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___How much?___

Number of years?____________If not a current user, year quit________________

Attempts to quit: __________

Are you exposed to 2nd hand smoke regularly? If yes, please explain:____

____

Alcohol Intake

Have you ever used alcohol? Yes____ No____

If yes, how often do you now drink alcohol?

- ❑ No longer drink alcohol
- ❑ Average 1-3 drinks per week
- ❑ Average 4-6 drinks per week
- ❑ Average 7-10 drinks per week
- ❑ Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes____ No____

Have you ever had a problem with alcohol? Yes____ No____

If yes, indicate time period (month/year) From__________ to __________

Other Substances

Do you currently or have you previously used recreational drugs? Yes____ No____

If yes, what type(s) and method? (IV, inhaled, smoked, etc.)___________________________________

____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes___No___

If yes, indicate which

- ❑ Lead
- ❑ Arsenic
- ❑ Aluminum
- ❑ Cadmium
- ❑ Mercury

Sleep & Rest History

Average number of hours that you sleep at night? Less than 10__ 8-10___ 6-8___ less than 6___

Do you:

- ❑ Have trouble falling asleep?
- ❑ Feel rested upon wakening?
- ❑ Snore?
- ❑ Have problems with insomnia?
- ❑ Use sleeping aid?

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Exercise History

Do you exercise regularly? Yes____ No____

If yes, please indicate:

Type of exercise	Times/week 1x	2x	3x	4x/+	Length of session ≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc.)								
Other (please indicate)								

If no, please indicate what problems limit your activity (low motivation, fatigue after exercising, etc.)

____

____

Social History

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

Stress/Psychosocial History

Are you overall happy? Yes____ No____

Do you feel you can easily handle the stress in your life? Yes ____ No _____

If no, do you believe that stress is presently reducing the quality of your life? Yes____ No____

If yes, do you believe that you know the source of your stress? Yes____ No____

If yes, what do you believe it to be?____

Have you ever contemplated suicide? Yes____ No____

If yes, how often? ______ When was the last time?______

Have you ever sought help through counseling? Yes____ No____

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If yes, what type? (e.g. psychologist, counselor, etc.)________________________________

Did it help?___________

How well have things been going for you?

	Very well	Fine	Poorly	Very poorly	Does not apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

Which of the following provide you emotional support? *Check all that apply*

❑ Spouse ❑ Family ❑ Friends ❑ Religious Spiritual ❑ Pets ❑ Other _________

Have you ever been involved in abusive relationships in your life? Yes ___ No___

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes__ No___

Did you feel safe growing up? Yes ___ No___

Was alcoholism or substance abuse present in your childhood home? Yes ___ No___

Is alcoholism or substance abuse present in your relationships now? Yes ___ No___

How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important b. _____ somewhat important c. _____ extremely important

Do you practice meditation or relaxation techniques? Yes ___ No ___

If yes, how often? ______________

Check all that apply:

❑ Yoga ❑ Meditation ❑ Visualization ❑ Breathing ❑ Tai Chi ❑ Prayer ❑ Other

Hobbies and leisure activities, what do you do for fun:

____

____

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Is there anything that you would like to discuss with the doctor today that you feel was not covered on this form?

Comments ____

____

____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and wellbeing.

Yours in Health,

Dr. Annette Kutz Schippel

This questionnaire is an adaptation of the Comprehensive Health History created by Wayne L. Sodano, D.C., D.A.B.C.I. and Ron Gristanti, D.C., D.A.B.C.O., M.S. at the Functional Medicine University. Sequoia Education Systems, Inc.

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HIPAA Right of Access Form for Family Member/Friend

I, ____, direct Dr. Annette Kutz Schippel and Endocrine Wellness to disclose and release my protected health information described below to:

Name: ____ Relationship:_________________________

Contact information: ____

____

Health Information to be disclosed upon the request of the person named above (Check one):

- ❑ Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR
- ❑ Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
    - ❑ Mental health records
    - ❑ Communicable diseases (including HIV and AIDS)
    - ❑ Alcohol/drug abuse treatment
    - ❑ Other (please specify): ____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ❑ An electronic record
- ❑ Hard copy

This authorization shall be effective until (Check one):

- ❑ All past, present, and future periods, OR
- ❑ Date or event:____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers.)

____ ____________________
Name of Individual Giving Authorization Date

____
Signature

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