Health Survey

This is an extensive health survey based on the work of Christiane Northrup, M.D., author of Women's Bodies, Women's Wisdom and The Wisdom of Menopause, which I believe are two of the best books on women's health available. Please take your time to fill out all of the questions, and feel free to address any of the questions with me or my Staff privately. Thank you.

FIRST NAME: _____ **LAST NAME:** _____

AGE: _____ **DATE:** _____

MARITAL STATUS: Single ☐ Married ☐ Divorced ☐ Widow ☐

INTENTION FOR THIS APPOINTMENT-(What are the top 3 symptoms you would like help with today?)_____
_____
_____

CURRENT/RECENT HEALTH CARE PROVIDERS/ PRIMARY CARE PHYSICIAN

Name Dates Care Provided

_____
_____
_____

GENERAL HEALTH:

Excellent	Good	Fair	Poor
☐	☐	☐	☐

ALLERGIES

Drug allergies (penicillin, etc.):

_____

Allergies to foods, pollens, etc.:

_____

MEDICATIONS

If this is a hormone consult, please list all hormones you have taken in the past, including birth control pills, infertility treatments, thyroid or adrenal hormones and all estrogen and progesterones.

Drug Name	When Used	Why Used	Side Effects

Current Prescription Medications (Include dosage):

Drug Name	Dosage	Used for

Vitamins/Supplements/Herbs

Vitamin	Used for

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PAST MEDICAL CONDITIONS

(For **current** problems, note under Current Medical Problems)

Breast Cancer	☐	Ovarian Cancer	☐	Other Cancer	☐
High Blood Pressure	☐	Varicose Veins	☐	Clotting Defects	☐
Bleeding Tendencies	☐	Heart Trouble	☐	Kidney Trouble	☐
Cervical Cancer	☐	Uterine Cancer	☐	Depression/Anxiety	☐
Stroke	☐	Phlebitis	☐	Rheumatic Fever	☐
Blood Transfusion	☐	Diabetes	☐	Osteoporosis	☐
Arthritis	☐	Epilepsy	☐	Eating Disorder	☐
Chronic Fatigue/Epstein Barr	☐	Asthma	☐	Environmental Illness	☐
Fractures	☐	Colitis	☐	Chemical Sensitivity	☐
Other	☐				

CURRENT MEDICAL SYMPTOMS/ CONDITIONS

Check any symptoms of present significance.

GENERAL					
Fever or Chills	☐	Unusual hair growth	☐	Fatigue/low energy	☐
Hot flashes	☐	Skin changes	☐	Cold extremities	☐
Night Sweats	☐	Weight Change	☐	Cold Intolerance	☐

ABDOMEN					
Bloating	☐	Constipation	☐	Change in bowel habits	☐
Heartburn	☐	Hemorrhoids	☐	Vomiting	☐
Indigestion	☐	Flatulence (gas)	☐	Nausea	☐
Diarrhea	☐	Cramps or pain	☐	Bloddy or tarry stools	☐

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HEAD					
Headaches	☐	Visual defects	☐	Sinus congestion	☐
Dizziness	☐	Hearing defects	☐	Fainting spells	☐

BLADDER					
Frequent urination	☐	Inability to hold urine	☐	Painful urination	☐
Blood in urine	☐	Inability to empty bladder	☐	Nighttime urination	☐

BREAST					
Lumps	☐	Bleeding	☐	Discharge	☐
Other	☐				

HOSPITALIZATIONS/OPERATIONS

Dates	Hospital	Diagnosis/Operation	Doctor

PREGNANCIES (including miscarriages and abortions)

Dates	How far along	Sex	Weight	Problems

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EMMANUELA WOLLOCH M.D. FACOG

GYNECOLOGICAL HISTORY

Date last period began:		Date of last pelvic exam:	
Date of last Pap Smear:		Age of first period:	
Was the above normal?	Yes ☐ No ☐		
Age of menopause:		(Note: If menopausal, answer the questions below for when you did)	
Date of last Mammogram:			
Do you do self-breast exams?	Yes ☐ No ☐	How often?	
Have you had a bone density screen?	Yes ☐ No ☐	When?	
Bone Density Results:			
Have you ever had an abnormal Pap?	Yes ☐ No ☐	When?	
Are you sexually active?	Yes ☐ No ☐	Do you have intercourse?	Yes ☐ No ☐
Are you trying to get pregnant?	Yes ☐ No ☐	How long?	
Current birth control method		Used for how long?	
Undesirable side effects?			
Past birth control methods:			
Normally (not on pills), the number of days from the start of one period to the start of the next:			
Number of days of flow:		Amount of bleeding:	
Premenstrual symptoms:	Yes ☐ No ☐	Starting when?	
Amount/severity of cramps:			
Any current changes in your normal pattern?			
Any bleeding between periods?	Yes ☐ No ☐	When?	
Any unusual pelvic pain, pressure or fullness?	Yes ☐ No ☐	Describe:	
Any unusual vaginal discharge or itching?	Yes ☐ No ☐	Describe:	
How long?		Past treatment:	
Menopausal Symptoms:	Yes ☐ No ☐		
Painful Intercourse/Vaginal dyness?	Yes ☐ No ☐		

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Any sexual concerns to discuss?	Yes ☐ No ☐		
Any pas history of tubal infection?	Yes ☐ No ☐	Any past history of DES exposure?	Yes ☐ No ☐
Any past history of sexually transmitted disease? (Herpes, chlamydia, genital warts)	Yes ☐ No ☐		
Treatment used?			

FAMILY HISTORY

Family Member	Living	Age	Cause of Death/Age
Mother	Yes ☐ No ☐		
Father	Yes ☐ No ☐		
Sister(s)	Yes ☐ No ☐		
Brother(s)	Yes ☐ No ☐		
Maternal Grandparents	Yes ☐ No ☐		
Paternal Grandparents	Yes ☐ No ☐		
Maternal Aunt(s)	Yes ☐ No ☐		
Paternal Aunt(s)	Yes ☐ No ☐		
Maternal Uncle(s)	Yes ☐ No ☐		
Paternal Uncle(s)	Yes ☐ No ☐		

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FAMILY HISTORY (continued)

	Mother	Father	Sister(s)	Brother(s)	Maternal Grandmother	Maternal Grandfather
Alcholism	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabities	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐
Other Addiction	☐	☐	☐	☐	☐	☐
Domestic/Sexual Abuse	☐	☐	☐	☐	☐	☐

	Paternal Grandmother	Paternal Grandfather	Maternal Aunt(s)	Paternal Aunt(s)	Maternal Uncle(s)	Paternal Uncle(s)
Alcholism	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabities	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Psychiatric Illness	☐	☐	☐	☐	☐	☐
Other Addiction	☐	☐	☐	☐	☐	☐
Domestic/Sexual Abuse	☐	☐	☐	☐	☐	☐

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HABITS

Dietary preferences/restrictions	Yes ☐ No ☐		
What did you eat/drink in the past 3 days (include all snacks, sodas, water, alcohol, coffee, fast food etc.)			
Breakfast			
Lunches			
Dinners			
Snacks	☐	☐	☐
Drinks	☐	☐	☐
Have you ever been diagnosed with an eating disorder or feel like you may have one?			
Describe your body image:			
Routine physical exercise? Type of exercise:			
For how many minutes?		How often?	
Tobacco Use (how much?)		How often?	
Alcohol use (how much?)		How often?	
Caffeine use (how much?)		How often?	
Mood altering substance use? - PAST/PRESENT (i.e. marijuana, cocaine, prescription drugs)			
How often do you laugh?			
What do you do to nurture yourself?			
How do you express yourself creatively?			
What gives you joy/passion?			
Do you have a spiritual practice?			

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Stresses

Family, work, self, etc…

One in every 3-4 women has been a victim of sexual abuse and/or physical violence. Is this an issue for us to discuss?	Yes ☐ No ☐

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