



Initial Visit - Health Maintenance Exam

Following is the initial visit form used at NEWS for Women.
Please copy this form, fill it out and bring it with you to NEWS for your
Initial Health Maintenance Exam (HME).

NEWS's ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultation. Health issues are influenced by many factors. Accurately assessing all of these factors and comprehensively managing them in an individualized treatment plan is the best way to deal with your particular health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time.

Vital Stats Information:

Date formed filled out: _____

Filled out by: _____

Referred by _____

Your Name: _____

Preferred name when addressing you: _____

Date of Birth (DOB): ____/____/____ Social Security #: ____/____/____

Your Occupation: _____

Present Address:

Street: _____ City: _____ State: _____ Zip: _____

If we can't contact you at home, please list alternative mailing address:

Street: _____ City: _____ State: _____ Zip: _____

Communications:

Home: (____)____/____ Work: (____)____/____

Beeper / Pager / Cell # (____)____/____

E-mail: _____

May we communicate general medical information via e-mail? ___Yes ___No

Would you like to be included on our e-newsletter mailings? ___Yes ___No

Parental Info: Mother's first and maiden name: _____

Father's full name: _____

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed ___Companion

Spouse / Companion's name: _____

Spouse / Companion's Date of Birth: ____/____/19____ Social Sec#: ____/____/____

Spouse / Companion's occupation: _____

Spouse / Companion's Work Phone: _____

Emergency:

Person to contact in an emergency (outside home): _____

Relationship: _____

Home: (____)____/____ Work: (____)____/____

Insurance Information:

I have no insurance. Please fill out next section "Additional Mode of Payment"

Primary Insurance: _____

Policy holder's name if different than patient: _____

Patient's relationship to policyholder: (circle) Spouse Dependent Child Other: _____

Their Social Security#: _____/_____/_____ Their Date of Birth: _____/_____/19____

Policy ID# of Patient: _____ Policy Group#: _____

Secondary Insurance: _____

Policy holder's name if different than patient: _____

Patient's relationship to policyholder: (circle) Spouse Dependent Child Other: _____

Their Social Security#: _____/_____/_____ Their Date of Birth: _____/_____/19____

Policy ID# of Patient: _____ Policy Group#: _____

Tertiary Insurance: _____

Policy holder's name if different than patient: _____

Patient's relationship to policyholder: (circle) Spouse Dependent Child Other: _____

Their Social Security#: _____/_____/_____ Their Date of Birth: _____/_____/19____

Policy ID# of Patient: _____ Policy Group#: _____

Additional Mode of Payment Other Than Insurance:

The below alternate mode(s) of payment may be used to finalize charges occurred by me at NEWS.

Insurance, as above.

Check

Cash

Credit Card: VISA / MasterCard / AmEx / Discover

#: _____ Expires: _____/_____/____ | Sec.Code: _____

Signed: _____ Date: _____

Office Consent Information:

Consent to Care: I consent to interview, examination, and routine testing at NEWS. This consent will remain in effect while I am an active patient at NEWS.

Signed: _____ Date: _____

Financial Consents: I have read the Financial Policy of NEWS and understand that I am financially responsible for all charges of services rendered to me, including but not limited to the remaining balance left after payment of possible insurance benefits. Any payments made to NEWS in error will be sent back to my insurance company to be reissued to me by my insurance company.

Signed: _____ Date: _____

HIPAA Consents: I have read the Privacy Policies of NEWS. I realize that these policies are mandated by the government via HIPAA-Health Insurance Portability and Accountability Act. I give my consent to use and disclose my health information for the following purposes: treatment, payment, healthcare operations, appointment reminders, treatment alternatives,

Date of last physical exam: _____ Practitioner's name/phone number: _____

Please list any of the following treatment therapies you have tried?

<input type="checkbox"/>	Acupuncture	<input type="checkbox"/>	Fasting	<input type="checkbox"/>	Vitamins/minerals
<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	Herbs	<input type="checkbox"/>	Nutraceuticals
<input type="checkbox"/>	Naturopathic Medicine	<input type="checkbox"/>	Homeopathy	<input type="checkbox"/>	Other
<input type="checkbox"/>	Massage	<input type="checkbox"/>	Yoga	<input type="checkbox"/>	

List current health problems and any type of treatment you are presently under going:

Health Problem	Mild/Mod/Severe	Treatment	Success

Social History:

Ethnic Heritage: African-American Asian Caucasian Hispanic Indian Mediterranean
 Middle Eastern Native American Northern European Other

Religious Preference: _____

Birthplace: _____

Last grade or degree attained: _____

List all states in which you have lived:

List all countries you have lived and traveled in:

Do you take or use?

	Present	Past	Comment
Alcohol (# drinks/wk)			
Cigarettes (#/day)			
Cigars (#/day)			
Chewing tobaccos(#/day)			
Exposed to passive smoke			
Recreational Drugs (#/day)			
Other street drugs:			

Arrested for DUI?			
Treated for drug/alcohol Pbms?			
Use seatbelts?			
Use sunscreens?			

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poor	Does Not Apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boy/girl friend					
With your children					
With your parents					
With your spouse					

Please list hobbies and leisure activities:



Your Family's Health: (Please research this!)

___ Adopted. I have (___No ___Limited ___Total) health information of my biological parents.

M=Maternal P=Paternal GM=Grandmother GF=Grandfather N/A=Not applicable

Major health problems= alcoholism, arthritis, blood diseases, blood pressure, cancers (list type: colon, breast, ovary, etc), diabetes, heart problems, high cholesterol, mental problems (list type: depression, Alzheimer's, etc), muscular problems, premature menopause, strokes, thyroid problems, obesity, osteoporosis, others.

First Name	Birth Yr	Major Health Problems	General Health	Cause of Death	Age of Death
Mother _____	19 _____	_____	___ Good ___ Poor	_____	_____
MGM _____	19 _____	_____	___ Good ___ Poor	_____	_____
MGF _____	19 _____	_____	___ Good ___ Poor	_____	_____
Father _____	19 _____	_____	___ Good ___ Poor	_____	_____
PGM _____	19 _____	_____	___ Good ___ Poor	_____	_____
PGF _____	19 _____	_____	___ Good ___ Poor	_____	_____
Sibs _____	19 _____	_____	___ Good ___ Poor	_____	_____
Sibs _____	19 _____	_____	___ Good ___ Poor	_____	_____
Sibs _____	19 _____	_____	___ Good ___ Poor	_____	_____
Sibs _____	19 _____	_____	___ Good ___ Poor	_____	_____
Sibs _____	20 _____	_____	___ Good ___ Poor	_____	_____
Spouse _____	19 _____	_____	___ Good ___ Poor	_____	_____
Child _____	_____	_____	___ Good ___ Poor	_____	_____
Child _____	_____	_____	___ Good ___ Poor	_____	_____
Child _____	_____	_____	___ Good ___ Poor	_____	_____

Child _____ Good Poor _____

Others living in household:

_____ 19 _____ Good Poor _____

_____ 19 _____ Good Poor _____

_____ 19 _____ Good Poor _____

Do you have a family history of:

	No	Yes	If yes, Whom
Alzheimer's/Dementia			
Memory Loss w/o Dementia			
Breast Cancer			
Colon Cancer			
Diabetes			
Epilepsy			
Glaucoma			
Heart Disease/Attack			
Hypertension			
Kidney Disease			
Macular Degeneration			
Lung Cancer			
Mental Illness			
Osteoporosis			
Ovarian Cancer			
Prostate Cancer			
Skin Cancer/Melanoma			
Stroke			
Thyroid Disease			
Other:			

Any other family history we should know about? No Yes, explain:

Is your family and close friends supportive of any illnesses you might have? Does not apply
 No Yes (Explain either answer)

Personal History:

Allergies: Allergies to medications, supplements, foods, environmental or other items:

None Yes, please list:

Childhood History:

Did your mother take DES while she was pregnant with you? ___No ___Yes, Explain

Questions...	No	Yes	Don't Know	Comment
Were youa full term baby?				
....a preemie?				
....breast fed?				
....bottle fed?				
As a child did you eat a lot of sugar &/or candy?				

Immunizations (please research): ___I do not take immunizations ___ I have never taken immunizations

Immunization	Yes	No	Date Last Given:	Comment
Baby shots (DPTP)				
Baby shots (MMR)				
HIB for meningitis				
Hepatitis B (series)				
HPV (series)				
Influenza				
Tetanus (lock jaw)				
Pneumonia Vaccine				
Shingles Vaccine				
TB-tine skin test				
MMR				
Chicken Pox Vaccine				
Do you usually get a yearly flu shot?				
Females: Are you protected against German Measles?				
Males: Have you ever had mumps?				

Medications: Do you regularly take medication (s) prescribed by a doctor? ___No ___If Yes: please list.

Name of current medication:	Dosage and amount:	Reason for taking the drug:

Have you taken any of the following medications?

	Present Use	Past Use	Amount & Frequency
Antacids			
Aspirin / Anacin / NSAIDS			
Birth control pills			
Heparin			
Laxatives			
Nasal sprays			
Sleeping pills			
Steroids			
Thyroid			
Tranquilizers			

How often have you taken antibiotics?

	< 5 times	> 5 times	Comment
Infancy/childhood			
Teen			
Adulthood			

How often have you taken steroids?

	< 5 times	> 5 times	Comment
Infancy/childhood			
Teen			
Adulthood			

Nutraceuticals: Please provide a complete list all vitamins, minerals, herbs, and supplements you take on a regular basis. If your supplement is not listed, be sure to add it.

Name	Dosage per day	Supplement Manufacturer
Multivitamin/Mineral		
Vitamin C		
Vitamin D		
Vitamin E		
EPA/DHA		
Evening Primrose/GLA		
Calcium		
Magnesium		
Zinc		
Minerals		
Acidophilus/Bifidus		
Digestive enzymes		
Amino Acids		
CoQ10		
Antioxidants		

Herbs-Teas		
Herbs-Extracts		
Chinese Herbs		
Ayurvedic Herbs		
Homeopathy		
Bach Flowers		
Protein Shake		
Superfoods		
Liquid meals		
Other		

General Questions:

	No	Yes	Comments
List your blood type.			Type= Rh=
Have you ever had a blood transfusion?			Year=
Any adverse reactions from blood?			
Last dental exam:			Date:
Do you have dentures?			
Do you have any sores in your mouth?			
Do you have mercury amalgam fillings?			
Do you have root canals?			
Any cavities within the last 2 years?			
Bleeding gums?			
Do you have trouble hearing?			
Do you use a hearing device?			
Do you wear glasses?			
Do you wear contacts?			
Do you have any artificial joints or implants?			List:
Have you been exposed to any toxic metals?			Metal: __arsenic __aluminum __cadmium __lead __mercury Where:
Do you feel worse at certain times of the year?			__Spring __Summer __Fall __Winter
Do odors affect you?			
Sun exposure?			SPF# routinely used:
Do you consider yourself:			__under weight __over weight __just right
How much do you think you weigh?			
Without trying, have you lost or gained 10 lbs. or more in the last three months?			
Exercise: Type= Frequency=			Duration= Started:
Have you had a recent change in your ability to:			__see __hear __taste __smell __feel hot/cold sensations __move around __sit upright __stand __walk __run __pick up things __swing your arms freely __turn your head __wiggle fingers
Do you prefer:			__warmth / __cold / __no preference
Is your sleep disturbed at the same time each night?			Explain:

	No	Yes	
If female , do you perform Breast self-examination monthly?			If not monthly, how often?
With whom do you live?			List: Name/age/relationship
Have you or your family experienced any major life changes?			Explain:
Have you experienced any major life losses in life?			Explain:
Do you have pets or farm animals? (list)			Pets/Animals= Do they live: __inside __outside __both
How much time have you lost from work or school in the past year?			__0-2 days __3-14 days __>15 days

Quick Stress Score:

Rate the level of stress you are experiencing over the last 30 days on a scale of 1 to 10 (1 being the lowest)._____

-1-	-2-	-3-	-4-	-5-	-6-	-7-	-8-	-9-	-10-
-----	-----	-----	-----	-----	-----	-----	-----	-----	------

Identify the major causes of your stress:_____

Describe your diet:

Eat a mixed food diet	Follow diabetic diet	Eat recklessly and unabated
Eat: __meat __fish __poultry __eggs __dairy __beans	Follow: __The Zone/ __ Atkins __South Beach __Mediterranean Diet	Eat sweets, sodas, ice cream
Limit/avoid red meats	Eat Hi protein / Lo-fat	Eat fried foods
Vegetarian	Eat Lo carb / Right fats	Diet frequently
__Vegan __Ovo-Lacto	Restrict total calories	Skip meals
Eat whole grains, cereals	Specific food restriction: __dairy __wheat __eggs __soy __corn __peanuts __sugar __MSG __Other	
Eat mainly fruits & veggies	Restrict dairy	
High fiber diet	Restrict __Salt __Fat __Sugar	
Blood type diet		

Dietary questions:

List your favorite foods:	
List number of meals you eat per day:	
List number of times you eat out per week:	
List favorite restaurant:	

How much of the following do you consume each day on the average?

Product	Amount/day	Product	Amount/day
Candy		Water (#glasses/day)	
Cheese		Wine (# 6oz glass/day)	
Cups of caffeinated coffee		Beer (# 6oz glass/day)	
Cups of black tea		Liquor (# ounces /day)	
Cups of decaff coffee/tea		Ice Cream	
Cups of green tea		Salty foods	
Cups of hot chocolate		Slices of bread, rolls	
Colas with caffeine		Red meat (#times/wk)	
Colas without caffeine		Fish (#times/wk)	

Elimination Habits: Please mark in the chart below, information about your bowel habits.

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

Intestinal gas: Daily Occasionally Excessive Present with pain Foul smelling Little odor

Personal History: (List dates to the side):

Medical/Injuries/Surgical:

Medical Illness:	Present	Past/Date/Age	Comment
Alcoholism			
Anemia			
Aneurysm, Belly			
Aneurysm, Abdomen			
Anorexia/Bulimia			
Arthritis			
Asthma			
Blood Clots / Pulmonary Embolism			
Bleeding Pbms /Easy Bruising			
Blood Transfusion(s)			
Blood in stools			
Bronchitis			

Cancer			List type
Cardiovascular Disease			
Change in moles			
Chest Pain			
Chronic Cough			
Chronic Fatigue Syndrome			
Cough up blood			
Clotting Pbms			
Constipation			
Collagen Vascular Disease (Lupus)			
Crohn's Disease or Colitis			
Depression			
Diabetes / Insulin Resistance			
Diarrhea			
Eczema			
Embolism			
Eye problems			
Earaches/infections			
Emphysema			
Eating Pbms/Anorexia/Bulimia			
Epilepsy / Convulsions / Seizures			
GallBladder Pbms / Gallstones			
Glaucoma			
Gout			
Growth in Neck			
Hemorrhoids			
Headaches			
Head colds, recurrent			
Heart Attack / Angina			
Heart Murmur/			
Heart Failure			
Hepatitis / __Liver Disease			
Hernia			
High Blood Pressure			
High Cholesterol/Lipids			
Irritable Bowel			
Jaundice			
Joint Pbms / Pain / Swelling			
Kidney Disease/Kidney Stones			
Leg cramps/ walking /at night			
Liver Disease			
Lung Disease / TB			
Memory Loss			
Migraines			
Mitral Valve Prolapse			
Muscle Pbms / Pain			
Nausea / vomiting / blood?			
Neuritis			

Neurological Pbms			
Nose bleeds, recurrent			
Obesity			
Osteoporosis			
Pain in arms			
Palpitations, heart flutters			
Prostate Pbms			
Psychological Illness/ Depression			
Rectal pain with BM			
Shortness of breath			
Sinus problems			
Stroke/CVA			
Stomach pains			
Swelling in hands,feet,legs			
Thyroid disease			
Urinary incontinence			
Urinary infections			
Urinary pain / blood?			
Urinary frequency			
Urinary urgency			
Times urinate during day_____			
Night_____			
Varicose veins			
Vision changes			
Injuries:	Date	Age	Comment
Back Injury			
Broken (describe)			
Head Injury			
Neck Injury			
Other:			
Surgical Procedures:	Date	Age	Comment
Appendectomy			
Breast Biopsy			
Breast Cancer			
Breast Implants			
Bladder Repair			
Cesarean Section			
Colon Cancer			
Colposcopy			
Dental Surgery			
D & C			
Eye/LASIK			
Gall Bladder			
Gastric By-Pass Surgery			
Heart By-pass Surgery			
Hemorrhoids			
Hernia R / L			

Hysterectomy			
LEEP			
Ovary R / L			
Spine			
Tonsils			
Tumor			
Vaginal Repair			
Varicose Veins			
Other:			

Have you ever been advised to have any medical procedure which has not been done? ___No ___Yes, give details:

Have you ever been advised to have surgery, but didn't? No_____ Yes_____, explain

Other than surgery, have you ever been hospitalized? ___No ___Yes, Explain

Medical Testing Results: Please complete. Bring test copies with you.

Result: N=normal; A=abnormal; ? not sure; If not done--leave blank

Test	Date Done:	Results:
Barium enema		
Bone Density		Hip (femur neck): _____ spine(L2-L4): _____
CT scan abdomen		
CT scan Brain		
CT scan Spine		
Chest x-ray		
Colonoscopy		
EKG		
Gallbladder Testing		
GI series		
Kidney x-ray		
Liver scan / biopsy		
Mammogram (women)		
MRI brain		
Neck x-ray		
Neurology exam		
Pap Test (Women)		
Sleep studies		
Stress test		
Thyroid Scan		

Ultrasound		Where:
Upper GI Xray(UGI)		
Arthritis Testing		ANA: _____, RA= _____, Sed Rate= _____, Uric Acid= _____
Candida tests		
Fasting Blood Sugar / HgbA1c		
Food allergies		
Gluten allergy		
Hepatitis Aby		
HIV		
H. pylori Testing		
Hemoglobin A1c		
Homocysteine		
Hormone levels		E2_____ P4_____ T_____ FSH_____ PRL_____ DHEA_____ DHT_____ Cortisol_____
Insulin Resistance		Fasting: insulin_____ glucose_____ 2 hr: insulin_____ glucose_____
Lipid Profile		Chol_____ LDL_____ HDL_____ TG_____ Chol/HDL ratio_____
Liver tests		
Lyme test		
PSA (men)		
Stool tested for Blood		Hemocult:_____
T.B. Test		
Thyroid		TSH_____ /Free T3_____ /Free T4 _____
Other testing		

Other Medical Knowledge: Is there any other medical information I have not asked about, but you feel I should know about you and/or your family? Please explain.



MSQ - Medical Symptom Questionnaire: A Functional Medicine Assessment

DIRECTIONS FOR COMPLETING THE QUESTIONNAIRE:

Rate the following symptoms based upon your typical health profile for the last 30 days.

Use the following "Point Scale":

- 0= **Never or almost never** have the symptoms
- 1= **Occasionally** have symptom, effect is **NOT severe**
- 2= **Occasionally** have symptom, effect is **severe**
- 3= **Frequently** have symptom, effect is **NOT severe**
- 4= **Frequently** have symptom, effect is **severe**

Be sure to add the points up for each individual group of symptoms.

At the end of the questionnaire, don't forget to tally the "GRAND TOTAL" of all of the symptom groups.

SYMPTOMS	0	1	2	3	4
HEAD					
Headache					
Faintness					
Dizziness					
Insomnia					
				Total=	<input type="text"/>
EYES					
Watery, itchy eyes					
Swollen, reddened, or sticky eyelids					
Bags or dark circles under eyes					
Blurred or tunnel vision					
				Total=	<input type="text"/>
EARS					
Itchy ears					
Earaches, ear infections					
Drainage from ears					
Ringing in ears, hearing loss					
				Total=	<input type="text"/>
NOSE					
Stuffy nose					
Sinus problems					
Hay fever					
Sneezing attacks					
Excessive mucus formation					
				Total=	<input type="text"/>
MOUTH/THROAT					

Chronic cough					
Gagging, frequent need to clear throat					
Sore throat, hoarseness, loss of voice					
Swollen or discolored tongue, gums, lips					
Canker sores					
				Total=	<input type="text"/>
SKIN					
Acne					
Hives, rashes, dry skin					
Hair loss					
Flushing, hot flashes					
Excessive sweating					
				Total=	<input type="text"/>
HEART					
Irregular or skipped heartbeats					
Rapid or pounding heartbeat					
Chest pain					
				Total=	<input type="text"/>
LUNGS					
Chest congestion					
Asthma, bronchitis					
Shortness of breath					
Difficulty breathing					
				Total=	<input type="text"/>
DIGESTIVE TRACT					
Nausea, vomiting					
Diarrhea					
Constipation					
Bloated feeling					
Belching, passing gas					
Heartburn					
Intestinal/stomach pain					
				Total=	<input type="text"/>
JOINTS/MUSCLES					
Pain or aches in joints					
Arthritis					
Stiffness or limitations of movement					
Pain or aches in muscles					
Feeling of weakness or tiredness					

				Total=	<input type="text"/>
WEIGHT					
Binge eating/drinking					
Craving certain foods					
Excessive weight					
Compulsive eating					
Water retention					
Underweight					
				Total=	<input type="text"/>
ENERGY/ACTIVITY					
Fatigue, sluggishness					
Apathy, lethargy					
Hyperactivity					
Restlessness					
				Total=	<input type="text"/>
MIND					
Poor memory					
Confusion, poor comprehension					
Poor concentration					
Poor physical coordination					
Difficulty in making decisions					
Stuttering or stammering					
Slurred speech					
Learning disability					
				Total=	<input type="text"/>
EMOTIONS					
Mood swings					
Anxiety, fear, nervousness,					
Anger, irritability, aggressiveness					
Depression					
				Total=	<input type="text"/>
OTHER					
Frequent illness					
Frequent or urgent urination					
Genital itch or discharge					
				Total=	<input type="text"/>
			<i>Grand</i>	Total=	<input type="text"/>



Life Change Index

If an event has been true for you in the past year or will occur in the near future,
circle the number in the right column. Total the points.

	Mild / Mod / Great		Mild / Mod / Great
Death of a spouse	80 / 100 / 120	Begin or end school	25 / 30 / 35
Divorce	65 / 75 / 85	Difficulties with peer group	25 / 30 / 35
Marital separation	55 / 65 / 75	Trouble with in-laws	25 / 30 / 35
Jail term	55 / 65 / 75	Problem teenager(s) in the home	25 / 30 / 35
Loss of self confidence	55 / 65 / 75	Change in living conditions	20 / 25 / 30
Death of close family member	50 / 60 / 70	Revision of personal habits	20 / 25 / 30
Injury to reputation	50 / 60 / 70	Trouble with boss	20 / 25 / 30
Personal injury or illness	45 / 50 / 55	Change in living conditions	20 / 25 / 30
Retirement	40 / 45 / 50	Small children in the home	20 / 25 / 30
Marriage	45 / 50 / 55	Change in work hours or conditions	15 / 20 / 25
Loss of job	45 / 50 / 55	Change in residence	10 / 20 / 30
Change in quality of religious life	45 / 50 / 55	Change in school	15 / 20 / 25
Marital reconciliation	40 / 45 / 50	Change in recreation	15 / 20 / 25
Change in health of family member	40 / 45 / 50	Change in church activities	15 / 20 / 25
Pregnancy	35 / 40 / 45	Change in social activities	10 / 15 / 20
Sex difficulties	35 / 40 / 45	Mortgage or loan less than \$20,000	10 / 15 / 20
Gain of new family member	35 / 40 / 45	Change in sleeping habits	10 / 15 / 20
Business readjustment	35 / 40 / 45	Change in number of family get togethers	10 / 15 / 20
Change of financial state	35 / 40 / 45	Change in eating habits	10 / 15 / 20
Death of close friend	30 / 35 / 40	Vacation	10 / 15 / 20
Change to different line of work	30 / 35 / 40	Christmas (if approaching)	10 / 15 / 20
Change in relationship with spouse	30 / 35 / 40	Minor violation of the law	10 / 15 / 20
Taking over major financial responsibility	25 / 30 / 35	*Other:	*
Foreclosure of mortgage or loan	25 / 30 / 35	*Other:	*
Change in responsibilities at work	25 / 30 / 35	**TOTAL OF BOTH COLUMNS =	
Son/Daughter leaving home	25 / 30 / 35		
Outstanding personal achievements	25 / 30 / 35		
Spouse begins or stops work	25 / 30 / 35		

****A stress index of over 300 shows significant enough stress to interfere with your health! NEWS recommends serious pursuit of activities to reduce this score.....otherwise, during the next year, your health may suffer.**

NOTES:



Women's Questionnaire

The following questions are designed to assess your Gynecological Health. Each question is very important, but if you feel you would rather not answer the question, you may skip it.
Please complete the form, print it out and bring it with you to your initial visit.

	Present-Year	Past-Year	Comments:
Date of last Pap test:			Normal / Abnormal, Explain:
Date of last menses			
Date of last Mammogram:			Normal / Abnormal, Explain:
All Women: Do you have a history of.....? Check positives and include dates.			
Abnormal Pap Smear?			
Colposcopy?	.	.	
Cryosurgery?	.	.	
LEEP?	.	.	
Laser Surgery?	.	.	
Birth Control Usage:			
Abstinence?	.	.	
Oral Contraceptives?			
Contraceptive Vaginal Ring?			
Contraceptive Patch?			
Condoms/Foam?	.	.	
Diaphragm/Cx Cap?	.	.	
Depo-Provera?	.	.	
IUD?	.	.	
Partner uses BC?	.	.	
Spermicides?	.	.	
Tubal-Ligation?	.	.	
Vasectomy?	.	.	
Withdrawal?	.	.	
Have you ever had any of these cancers?			
Breast Cancer?	NO	Yes	Date:
Cervical Cancer?	NO	Yes	Date:
Ovarian Cancer?	NO	Yes	Date:
Vaginal Cancer?	NO	Yes	Date:
Vulvar Cancer?	NO	Yes	Date:
Other?	NO	Yes	List
Have you ever had any of these surgeries?			
Breast Biopsy?	NO	R / L	Date:
Breast Implants?	NO	Yes	Date:
Bladder Repair?	NO	Yes	Date:

Cervix Biopsied, Frozen, LEEPed?	NO	Yes	Explain:
D&C?	NO	Yes	Date:
Mastectomy?	NO	R / L	Date:
Laproscopy?	NO	Yes	Date:
Tubal Ligation?	NO	Yes	Date:
Myomectomy?	NO	Yes	Date:
Hysterectomy?	NO	Yes	Date:
Ovaries removed?	NO	R / L	Date:
Do [or have you] experienced:			
Clotting Problems?	NO	Yes	Date:
DES Exposure?	NO	Yes	Date:
Blood clots?	NO	Yes	Date:
Ovarian cysts?	NO	Yes	Date:
Ovarian surgery?	NO	Yes	Date:
Pelvic infections?	NO	Yes	Date:
Uterine disease?	NO	Yes	Date:
Adenomyosis?	NO	Yes	Date:
Fibroids?	NO	Yes	Date:
Have you ever had Urinary Tract Problems:			
Infections?	NO	Yes	Date:
Incontinence?	NO	Yes	Date:
Compromises Socialization?	NO	Yes	
Weight Changes....			
....loss of 10 lbs in the last 3 months?	NO	Yes	
....gain of 10 lbs in the last 3 months?	NO	Yes	
Heaviest adult weight=			
Lightest adult weight=			
Breast Issues:			
Discharge ?	.	.	
Mass?	.	.	
Surgery?	.	.	
Mother or sister with breast cancer?	NO	Yes	
Do you do Monthly Breast Exams?	NO	Yes	
Hormonal/Mental Health:			
	RATING?	PROBLEM ?	
Anxiety?	0 1 2	NO / Yes	
Fear of being alone in public?	0 1 2	NO / Yes	
Experience panic attacks?	0 1 2	NO / Yes	
Feel nervous?	0 1 2	NO / Yes	
Feel lonely or depressed?	0 1 2	NO / Yes	
Frequent nightmares?	0 1 2	NO / Yes	
Headaches?	0 1 2	NO / Yes	
Dizziness?	0 1 2	NO / Yes	
Memory loss?	0 1 2	NO / Yes	

Anorexia/Bulimia?	0	1	2	NO / Yes	
Food cravings premenstrual?	0	1	2	NO / Yes	
PMS?	0	1	2	NO / Yes	
Endometriosis?	0	1	2	NO / Yes	
Skin eruptions with menses?	0	1	2	NO / Yes	
Excess hair growth?	0	1	2	NO / Yes	
Miscarriage(s)?	0	1	2	NO / Yes	
Infertility?	0	1	2	NO / Yes	
Hot flushes?	0	1	2	NO / Yes	
Night sweats?	0	1	2	NO / Yes	
Palpitations?	0	1	2	NO / Yes	
Sleep disturbances?	0	1	2	NO / Yes	
Chest pressure/pain?	0	1	2	NO / Yes	
Shortness of breath?	0	1	2	NO / Yes	
Numbness?	0	1	2	NO / Yes	
Weakness or fatigue?	0	1	2	NO / Yes	
Tired without reason?	0	1	2	NO / Yes	
Chronic fatigue?	0	1	2	NO / Yes	
Pain in bone joints?	0	1	2	NO / Yes	
Pain in muscles?	0	1	2	NO / Yes	
Brittle nails?	0	1	2	NO / Yes	
Hands/feet cold?	0	1	2	NO / Yes	
Hair loss?	0	1	2	NO / Yes	
Loss of urinary control?	0	1	2	NO / Yes	
Vaginal dryness?	0	1	2	NO / Yes	
Loss of sexual desire?	0	1	2	NO / Yes	
Pain w/intercourse?	0	1	2	NO / Yes	
Disrupted function: Home?	0	1	2	NO / Yes	
Disrupted function: Work?	0	1	2	NO / Yes	
Other symptoms?(List)	0	1	2	NO / Yes	

Menses History for Maidens (Young Women) and Mothers (Reproductive Aged Women):

Age at 1 st menses:	Yrs		
How long does your menses last?	_____days		
How many days between menses?	_____days		
With your menses, do you have:			
Cramps?	NO	Yes	
Pain?	NO	Yes	
Bloating?	NO	Yes	
Sore breasts?	NO	Yes	
How do you treat these discomforts?			
Do you ever spot between menses?	NO	Yes	
Do you ever pass "brown sludge" before your menses?	NO	Yes	

Menses History for Matrons (Postmenopausal women):			
Age at 1st menses:			
Age at natural menopause:			
Age at surgical menopause:			
Since menopause, have you spotted?	NO	Yes	
If yes, describe:			
Do you take ANY form of hormones?	NO	Yes	List:
How long have you been on HRT?			
Pregnancy History			
Total number of pregnancies:			
Children born:	Hospital=	Home=	
Birth weight largest baby:			
Birth weight smallest baby:			
Number of births:	Vaginal_____	Cesarean_____	
Were you given Rhogam?	NO	Yes	
Was your 'Sugar Test' normal during your pregnancy?	Yes	NO	Explain:
Was your 'blood pressure' normal during your pregnancy?	Yes	NO	
Did you breast feed any/all of your babies?	Yes	NO	
Sexual History:			
First pelvic exam today?	NO	Yes	
Have you had consenting sex?	NO	Yes	
Do you use tampons?	NO	Yes	
Victim of "date rape"?	NO	Yes	
Victim of sexual abuse?	NO	Yes	
Victim of incest?	NO	Yes	
Victim of domestic violence?	NO	Yes	
Do you feel you are no longer a victim but a survivor of your particular abuse?	NO	Yes	
Is a pelvic exam emotionally difficult for you?	NO	Yes	
Describe your sexual life:			
Celibate	.	Yes	
Single partner, long term	.	Yes	
Single partners, short term	.	Yes	
Multiple partners	.	Yes	
Number of partners within the last yr.	#_____		
Have you had sex with your present partner(s) for at least 4 months?	Yes	NO	
How often do you have sex?	____times per Day Week/Month/Year		
With whom:	___Self ___Men only ___Women only ___Both Sexes		
Type:	___Vaginal ___Oral ___Rectal		

Do you have pain with sex?	NO	Yes	
When does this occur?	___Penetration ___Deep Thrusting ___Orgasm ___Other:		
Do you get satisfaction from your sex life?	Yes	NO	
Are you bothered by this?	NO	Yes	
Would you be interested in doing something about this?	NO	Yes	
Are there any questions or problems about sex that you would like to discuss?	NO	Yes	
Partner Violence Screen:			
1. Have you been hit, kicked, punched, or otherwise hurt by someone in the past year?	NO	Yes	
	If so, by whom?	<input type="checkbox"/> Person in current relationship <input type="checkbox"/> Person in previous relationship <input type="checkbox"/> Someone else	
2. Do you feel safe in your current relationship?	NO	Yes	
3. Is there a partner from a previous relationship who is making you feel unsafe now?	NO	Yes	
STD's:			
Vaginal Discharge?	NO	Yes	
If Yes, explain:			
Genital Herpes or HSV?		Yes	Date:
Genital Warts or HPV?		Yes	Date:
Chlamydia?		Yes	Date:
Gonorrhea?		Yes	Date:
AIDS/HIV?		Yes	Date:
Do you feel that you have any reason to be concerned about your HIV status?	NO	Yes	
Do you desire testing for HIV?	NO	Yes	
Do you have any questions about STD's?	NO	Yes	

Three Main Questions:

List the three main questions/concerns you want answered/addressed at your initial visit.

- 1.
- 2.
- 3.

Thank you for choosing our office in your pursuit of wellness!