



## 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, health-related products or services. Please write in those services you do not consent to:

\*\*If you do not give your Consent for purposes of treatment, payment or healthcare operations we will not be permitted to use or disclose information about you and unless you pay your bill in full with cash at the time of service, we will not be able to provide you with healthcare treatment and services.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Fees Our Office Visit Charges Do Not Cover:**

Our office fees **DO NOT** cover the cost of any referrals, pap smears, laboratory, or pathology services. These charges will be filed to your insurance company, if applicable, by the lab performing the service. If the laboratory cannot collect on these charges for any reason, **YOU** will be responsible for these fees. So, please help by filling out your insurance information legibly, accurately and completely! Otherwise, YOU may be re-filing them to your insurance company for reimbursement.

**Disclaimer:** I realize that referrals, pap smears, laboratory, or pathology services are NOT included in any visit charges and that I am responsible for all additional costs ordered at NEWS.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**SUBMITTING YOUR DEMOGRPHICS TO LABORATORIES:**

NEWS uses your name and social security number in order to identify your lab work. If you have concern with this, let us know. Anonymity is offered in the case of sensitive testing like HIV testing. If you ever desire to remain anonymous, please inform us at the time of testing.

**A WORD OF CAUTION ABOUT SPECIALITY LABS:**

Many of our specialty labs do not accept Medicare or Workman's Compensation. Many insurance plans do not recognize specialty lab testing.

***Thus, before testing, be sure to check with your insurance company and be sure what they will and won't cover.***

If you plan to bill your insurance company, you will still need to pay 20% of the testing & handling fee at the time of blood draw. If your insurance company decides to deny the lab testing, you will then be responsible for this higher fee in full. Our specialty labs charge less for lab work when "paid-in-full" at the time of testing. So if you don't want this extra cost of processing your insurance, be prepared to pay at the time of testing! The lab will then send you a form to file with your insurance after lab processing.

**FUTURE LAB WORK:**

NEWS will handle all future lab charges in the above manner unless you inform us of changes in writing by submitting an updated laboratory charge form. Thank you for helping us make the financial and legal side of medicine easier.



**Past Health Care Providers:** Please list all others you have seen for your health care in the last five years?

Year	Name of Provider	MD/DO	DC/ND/DOM	Location	Problem	Outcome

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 you ....a 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?				
<b>Females:</b> Are you protected against German Measles?				
<b>Males:</b> 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=			Duration= Started:
Frequency=			
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 <b>female</b> , 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-
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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
Have you ever felt like you need			<input type="checkbox"/> No / <input type="checkbox"/> Yes / N/A
Have people annoyed you by			<input type="checkbox"/> No / <input type="checkbox"/> Yes / N/A
Have you ever felt guilty about			<input type="checkbox"/> No / <input type="checkbox"/> Yes / N/A

drinking?			
Have you ever needed a drink first thing in the morning to get rid of a hangover? (eye-opener)			__No / __Yes / N/A
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			
<b>Injuries:</b>	<b>Date</b>	<b>Age</b>	<b>Comment</b>
Back Injury			
Broken (describe)			
Head Injury			
Neck Injury			
Other:			
<b>Surgical Procedures:</b>	<b>Date</b>	<b>Age</b>	<b>Comment</b>
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 Brain		
CT scan Spine		
Chest x-ray		
Colonoscopy		
Colposcopy		
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		Hemoccult:____
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
<b>HEAD</b>					
Headache					
Faintness					
Dizziness					
Insomnia					
				<b>Total=</b>	<input type="text"/>
<b>EYES</b>					
Watery, itchy eyes					
Swollen, reddened, or sticky eyelids					
Bags or dark circles under eyes					
Blurred or tunnel vision					
				<b>Total=</b>	<input type="text"/>
<b>EARS</b>					
Itchy ears					
Earaches, ear infections					
Drainage from ears					
Ringing in ears, hearing loss					
				<b>Total=</b>	<input type="text"/>
<b>NOSE</b>					
Stuffy nose					
Sinus problems					
Hay fever					
Sneezing attacks					
Excessive mucus formation					
				<b>Total=</b>	<input type="text"/>
<b>MOUTH/THROAT</b>					

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

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



## Life Change Index

Circle the number in the right column that pertains to you. 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	<b>**TOTAL OF BOTH COLUMNS =</b>	
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:
<b>All Women:</b> Do you have a history of.....? Check positives and include dates.			
<b>Abnormal Pap Smear?</b>			
Colposcopy?	.	.	
Cryosurgery?	.	.	
LEEP?	.	.	
Laser Surgery?	.	.	
<b>Birth Control Usage:</b>			
Abstinence?	.	.	
Oral Contraceptives?			
Contraceptive Vaginal Ring?			
Contraceptive Patch?			
Condoms/Foam?	.	.	
Diaphragm/Cx Cap?	.	.	
Depo-Provera?	.	.	
IUD?	.	.	
Partner uses BC?	.	.	
Spermicidals?	.	.	
Tubal-Ligation?	.	.	
Vasectomy?	.	.	
Withdrawal?	.	.	
<b>Have you ever had any of these cancers?</b>			
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
<b>Have you ever had any of these surgeries?</b>			
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:
<b>Do [or have you] experienced:</b>			
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:
<b>Have you ever had Urinary Tract Problems:</b>			
Infections?	NO	Yes	Date:
Incontinence?	NO	Yes	Date:
Compromises Socialization?	NO	Yes	
<b>Weight Changes....</b>			
....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=			
<b>Breast Issues:</b>			
Discharge ?	.	.	
Mass?	.	.	
Surgery?	.	.	
Mother or sister with breast cancer?	NO	Yes	
Do you do Monthly Breast Exams?	NO	Yes	
<b>Hormonal/Mental Health:</b>			
	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 <sup>st</sup> 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	

<b>Menses History for Matrons (Postmenopausal women):</b>			
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?			
<b>Pregnancy History</b>			
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	
<b>Sexual History:</b>			
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	
<b>Describe your sexual life:</b>			
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	
<b>Partner Violence Screen:</b>			
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	
<b>STD's:</b>			
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!