Dr. Hundt's Walk of Wellness Healing Center

Female Health History Questionnaire

GENERAL INFORMATION

Name ____ Today's Date ________________________

Age _____ Date of Birth ______________ Height ________ Weight ________ Occupation ______________________
Are you pregnant? Yes ____ No _____ Are you breastfeeding? Yes ____ No _____
Are you cyclic? Yes ____ No _____ Are you in Menopause? Yes ____ No _____

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	January 2009	3 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Medication/Supplement/Food	Reaction
____	____
____	____
____	____
____	____

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes____ No____ If yes, please list. _____________________

____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes____ No____ If yes, how many? ________

If yes, please list which kinds. ____

How long have you had these fillings? ____

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes____ No____

Have you had any dental work done in the last 12 months? Yes____ No____

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MEDICATIONS & SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?
Yes ____ No _____ If yes, please describe:____

SLEEP/REST

Average number of hours you sleep ❑ >10 ❑ 8 – 10 ❑ 6 – 8 ❑ <6
Do you have trouble falling asleep? Yes ____ No _____ Do you get a second wind at night? Yes ___ No _____
Do you feel rested upon awakening? Yes ____ No _____
Do you have problems with insomnia? Yes ____ No _____
Do you snore? Yes ____ No _____
Do you use sleeping aids? Yes ____ No _____ Explain:__________________________________

LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? Yes ______ No _______ How many years? ____________ Packs per day: ____________
If yes, what type? Cigarette ________ Smokeless ________ Cigar ________ Pipe ________ Patch/Gum _________
Previous smoking: How many years? ______________ Packs per day: ___________________
Are you exposed to 2nd hand smoke? If yes, please explain: ______________________________________

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 oz. beer, 1.5 ounces spirits*

None _____ 1-3 _____ 4-6 _____ 7-10 _____ >10 _____

Previous alcohol intake? Yes ____ (Mild _____ Moderate _____ High _____)

CAFFEINE INTAKE

How many cups of coffee per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____

How many cans of soda per day? None _____ 1-3 _____ 4-6 _____ 7-10 _____

Is the soda you drink, diet soda? Yes ______ No _______

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PREGNANCY HISTORY (Check box if yes and provide number of)

❑ Pregnancies _______________ ❑ Caesarean _______________ ❑ Vaginal deliveries _____________

❑ Miscarriage _________________ ❑ Abortion _________________ ❑ Living Children ______________

❑ Postpartum depression ❑ Toxemia ❑ Gestational diabetes

❑ Baby over 8 pounds ❑ Breast feeding: for how long?___________________________________

FOR THE CYCLIC-AGE WOMAN

Age at 1st period:_____ Menses Frequency: ______ Length of period: _______ Pain: Yes____ No ____

Clotting: Yes _____ No _____ Has your period skipped? ______________ For how long? __________________

Last Menstrual Period: ________ How many days is your current cycle?

Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?

❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

Have you ever used hormonal contraception? Yes ____ No ____ If yes, when ______________________________

Use of hormonal contraception: ❑ Birth control pills ❑ Patch/Injection ❑ NuvaRing

Are you using the pill now? Yes ______ No ________ Did taking the pill agree with you? Yes ________ No ________

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ❑ Yes ❑ No

Date of last Mammogram ________________________ Breast Biopsy/Date ____________________________

Last PAP Test: ____________________________ Normal ________________ Abnormal __________________

Other information for us to know: ____

FOR THE WOMAN IN MENOPAUSE

Age at onset of menopause: __________________ Year of onset of menopause: __________________

When you were cycling, would you consider your cycle regular? Yes _____ No _____
If no, why? ____

When you were cycling, what was your typical menstrual flow? Light _____ Medium _____ Heavy _____

Have you had a hysterectomy? Complete (ovaries and uterus) _________ Partial (uterus only) ___________
Date of hysterectomy _________________ Reason for hysterectomy: ___________________________________

Date of last Mammogram _______________________ Breast Biopsy/Date _________________________________

Date of last Bone Density ______________________ Results: ❑ High ❑ Low ❑ Within normal range

Are you in menopause? Yes _______ No _______ Age at Menopause _______________

Do you take: ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone

❑ Provera ❑ Other ____

How long have you been on hormone replacement? ____

Other information for us to know: ____

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