Pure Health
Natural Medicine

Female Intake

Date: _____

Personal Information

Name: *(first, last)* _____ Maiden: _____

Preferred Name: _____ Sex: M F Date of Birth: _____ Age: _____

Street Address: _____

City: _____State:_____ Zip: _____ E-mail _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Occupation: _____ Work Phone: _____

Name of Spouse or Guardian: _____

Employer: _____Work Phone: _____

Last Physician Consulted: _____

Reason for that visit: _____

Emergency Contact:

Name: _____ Phone: _____

Who may we thank for referring you? *(fill in and/or circle all that apply)*

Friend _____ Professional Referral _____ Event _____

Internet Flier/Brochure Ad

What are your top health concerns?

1. _____

2. _____

3. _____

Current Medications:

Include prescription, over the counter, and any supplements.

Rx	**Vitamins/Herbs**

Drug Allergies: _____

Other Allergies: _____

Habits *(please list type, frequency and quantities)*:

Caffeine: _____

Alcohol: _____

Smoking: _____

Exercise:

Type:

Days per week:

Cross training:

Weight training:

Competitive events:

Number of competitions per month/year:

Training group/coach:

Diet *(Please list typical foods eaten at these meals)**:***

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

Please list any foods that you avoid.

Past Medical History:

Childhood Illnesses: _____

Adult Illnesses: _____

Hospitalizations: _____

Surgeries: _____

Injuries: _____

Family Health History: *(cause of death and age, where applicable)*

Mother:

- Grandmother:
- Grandfather:

Father:

- Grandmother:
- Grandfather:

Siblings:

What is your heritage? _____

Are you adopted? Yes No

Current and Past Health:

Blood type? _____

Current Weight: _____ Weight 1 year ago: _____

Maximum Weight: _____ Minimum Weight: _____

Please circle any symptoms/conditions that you have had or currently experiencing.

Night sweats
Fatigue/tiredness
Weight problems
Appetite changes
Fever
Eczema
Hair Loss
Skin tags
Acne
Skin rash
Headaches
Migraine
Head injury
Eye pain
Double vision
Tearing problems
Floaters in eyes
Hearing loss
Ringing
Earache
Dizziness
Frequent colds
Nose bleeds
Sinus problems
Bloody nose
Hay fever/allergies
Loss of smell
Snoring
Frequent sore throat
Sore tongue
Mouth sores

Hoarseness
Dental problems
swollen glands
Neck pain
Easy bleeding or bruising
History of anemia
Pain when breathing
Shortness of breath
History of positive tuberculosis
Asthma
Chest pain/discomfort
High blood pressure
Rheumatic fever
Heart murmur
Ankle swelling
Dizzy spells
Heart fluttering
Trouble swallowing
Heartburn
Ulcer history
Abdominal pain
Nausea
Vomiting
Blood in stool
abdominal bloating
Belching
Gas
Hemorrhoids
Hepatitis
Constipation
Diarrhea

Black stool
Polyps
Gallbladder stones
Pain with urination
Urinary frequency
dribbling
frequent bladder infections
Kidney stones
Blood in urine
Foul smelling urine
varicose veins
Pain in legs with walking
Swelling of legs
Joint pain or stiffness
History of broken bones
Muscle cramps or spasms
Weakness
Depression
Insomnia
Mood swings
Anxiety
Nervousness
Phobias
Suicidal thoughts/plans
Family hx- psychiatric disorders
Thyroid problems
Diabetes
Hypoglycemia
Weight gain
Weight loss

Please list any other symptoms/conditions, not listed above:

Women's Health

LMP (Last Menstrual Period): _____ FMP (Final Menstrual Period): _____

Menarche (First Period): _____ How long between your periods? _____

How long do you flow? _____ Do you have cramps? Y N How severe (1-10)? _____

Have you ever missed a period (and when)? _____ How often? _____

Births (mo/yr)	Sex	Type of Delivery	Complications	Name

Miscarriages: _____ Induced abortions: _____ Premature birth: _____

Have you ever been tested for or concerned about infertility? _____

Have you ever taken any of the following?

Birth control pill/patch Yes No Type: _____
HRT (Hormone Replacement Therapy): Yes No Type: _____
NHRT (Natural Hormone Replacement Therapy): Yes No Type: _____
Progesterone Cream (OTC): Yes No Type: _____

Do you have an immediate family history of Breast/Uterine/Ovarian cancer? Yes No

Date of most recent Bone Density Scan (DXA)? _____ Results: _____

When was your last mammogram? _____ Results: _____

When was your last colon cancer screen? _____ Results: _____

Have you ever had fibroid tumors? _____ Ovarian cysts? _____

Do you have pain or bleeding with intercourse? _____

Are you sexually active? _____ Is/are your partner(s) male or female? _____

When was your last Pap smear? _____ Where was it done? _____

Have you ever had an abnormal Pap smear? _____ When? _____ Result? _____

What was the method of treatment? _____

Do you suffer from?

Menstrual cramps……..	Yes	No
Breast tenderness……..	Yes	No
Low libido……	Yes	No
Vaginal dryness……	Yes	No
Insomnia……..	Yes	No
Cramping (uterine)……..	Yes	No
Memory loss……..	Yes	No
Weight gain/loss……..	Yes	No
Night sweats……..	Yes	No
Hot flashes……	Yes	No
Cystic breasts……	Yes	No
Excessive menstrual bleeding……	Yes	No
Acne……..	Yes	No
Mid-cycle pain……..	Yes	No
Irritability……..	Yes	No
Depression……	Yes	No
Hair loss……	Yes	No
Unwanted facial hair……	Yes	No
Infertility……..	Yes	No
Nipple discharge……	Yes	No
Yeast infections……..	Yes	No
Vaginal itching……	Yes	No
Herpes……..	Yes	No

Please list any other questions or concerns for this visit.