



The Center For Healthy Living & Longevity

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Adult Female Questionnaire

Today's Date: ____/____/____ BLOOD TYPE: _____

Patient Name: _____ Birth date: ____/____/____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular _____ Work: _____

Email: _____

Type of Health Insurance: PPO ____ HMO ____ Other _____

Occupation: _____ Social Security # _____

Previous Occupations: _____

Single ____ Married ____ Widowed ____ Divorced ____

Height: _____ Weight: _____

- Do you use tobacco? ____ Yes How much per day? _____ No
- Do you use alcohol? ____ Yes How much per day? _____ No
- Do you use caffeine? ____ Yes How much per day? _____ No
- Tea, Coffee or Chocolate? _____
- **Do you use artificial sweeteners? ____ Yes What type? _____ No**
- Do you drink carbonated beverages? ____ Yes How many per day? _____ No
- Do you have any pets? ____ Yes Type? _____ No
- Have you lived or traveled outside of the United States?
If so, when and where? _____

Allergies: Please check all that apply

____ Penicillin ____ morphine ____ dye allergies ____ seasonal (pollen) allergies

____ Codeine ____ aspirin ____ nitrate allergy ____ no known allergies

____ sulfa drugs ____ food allergies ____ pet allergies ____ other: _____

Please describe the allergic reaction you experienced and when it occurred: _____

Over-the-counter (OTC) issues: Please check all products that you used occasionally or regularly.

____ pain reliever	____ combination products (cough & cold reliever, Triaminic DM®)
____ aspirin	____ sleep aids (Excedrin PC®, Unisom®, Sominex®, Nytol®)
____ acetaminophen (Tylenol®)	____ antidiarrheals (Imodium®, Pepto Bismol®, Kaopectate®)
____ ibuprofen (Motrin IB®)	____ Laxatives / stool softener (Doxidan®, Correctol®)
____ naproxen (Aleve®)	____ Diet aids / weight loss products (Dexatrim®)
____ ketoprofen (Orudis KT®)	____ antacids (Maalox®, Mylanta®)
____ cough suppressant (Robitussin DM®)	____ acid blockers (Tagamet HB®, Pepcid C®, Zantac 75®)
____ antihistamine (Benadryl, Chlor-Trimeton®)	____ others: _____
____ decongestant (Sudafed®)	



Vitamin/Mineral Supplement Name

Date Started

Dosage

Describe your eating habits including the times you usually eat: (include deserts)

Breakfast

Lunch

Dinner

Type of Snacks

What foods to you crave?

Medical Conditions / Diseases: Please check all that apply to you.

- | | |
|---|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clotting problems |
| <input type="checkbox"/> High cholesterol or lipids (e.g. hyperlipidemia) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure (e.g. hypertension) | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers (e.g. stomach, esophagus) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Hormonal related issues | <input type="checkbox"/> Eye disease (e.g. glaucoma, etc.) |
| <input type="checkbox"/> Lung conditions (e.g. asthma, emphysema, COPD) | <input type="checkbox"/> Thyroid disease - goiter, nodules, low thyroid |
| <input type="checkbox"/> Other: | |

Please describe any past medical history:

Past Surgeries:



Current Prescription Medications:

Medication Name	Reason for Taking?	Strength	Date Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How often have you taken antibiotics?

Hormones previously taken	Date Started	Date Stopped	Reason
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever used oral contraceptives? _____ Yes _____ No
For how long and when? _____
If yes, any problems using oral contraceptives? _____ Yes _____ No
Please describe: _____

How many pregnancies have you had? _____ How many children? _____
Any interrupted pregnancies? _____ No _____ Yes
Have you had a hysterectomy? _____ No _____ Yes (date of surgery) _____
Ovaries removed? _____ No _____ Yes
Have you had a tubal ligation? _____ No _____ Yes
Describe any other surgeries: _____

Dental History

How many Silver/Mercury Amalgams do you have? _____
Recent cavities, crowns, root canals? Describe: _____
History of any Gum Disease? Describe: _____

Do you have a family history of any of the following?

Uterine cancer	_____ No	_____ Yes	Family member(s)	_____
Ovarian cancer	_____ No	_____ Yes	Family member(s)	_____
Breast cancer	_____ No	_____ Yes	Family member(s)	_____
Other Cancers	_____ No	_____ Yes	Family member(s)	_____
Heart disease	_____ No	_____ Yes	Family member(s)	_____
Osteoporosis	_____ No	_____ Yes	Family member(s)	_____
Diabetes	_____ No	_____ Yes	Family member(s)	_____
Hypertension	_____ No	_____ Yes	Family member(s)	_____
Allergies/Asthma	_____ No	_____ Yes	Family member(s)	_____
Alzheimer's/Dementia	_____ No	_____ Yes	Family member(s)	_____
Eczema	_____ No	_____ Yes	Family member(s)	_____

Any other family history we should know about?



Have you had any of the following tests performed?

Mammogram _____ No _____ Yes Date: _____ Result: _____
 Pap Smear _____ No _____ Yes Date: _____ Result: _____
 Bone Densitometry _____ No _____ Yes Date: _____ Result: _____

When was the date your last cycle? _____

How many days did it last? _____

Describe any change in your cycles for the past two years:

Please indicate your symptoms for the following conditions:

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	_____	_____	_____	_____
Uterine Fibroids	_____	_____	_____	_____
PMS (Pre-menstrual Syndrome)	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Carbohydrate Craving	_____	_____	_____	_____
Chocolate Craving	_____	_____	_____	_____
Constipation	_____	_____	_____	_____
Heavy/Irregular menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Dry Skin / Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Headaches/Migraines	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Sleep Disturbances / Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Ovarian Cysts	_____	_____	_____	_____
Endometriosis	_____	_____	_____	_____
Memory Loss	_____	_____	_____	_____
Incontinence/frequent urination	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Difficulty reaching orgasm	_____	_____	_____	_____
Decreased libido	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Thyroid Goiter	_____	_____	_____	_____
Heartburn/Indigestion	_____	_____	_____	_____
Diarrhea	_____	_____	_____	_____
Gas/Bloating	_____	_____	_____	_____



Do you have any risk factors for blood clots? (circle ones below)

- Cancer
- Prior blood clot (DVT)
- Advanced age
- Restricted mobility longer than 3 days
- Inherited clotting disorder
- Overweight
- Recent hospitalization
- Major surgery in previous 4 weeks
- Pregnancy or post partum
- Long plane or car trips (>4 hours) in previous 4 weeks
- Using birth control pills
- Take menopausal hormones by mouth
- Recent trauma
- Stroke
- Heart attack
- Heart Failure
- Nephrotic syndrome
- Ulcerative colitis
- Lower extremity fractures
- Systemic lupus erythematosus (SLE)
- Behcet syndrome

Lifestyle Questions

1. How often do you exercise? _____

2. During the past 12 months, how often have you felt excessive stress in your life?

Never _____ Occasionally _____ Often _____ Almost always _____

Have you experienced any major losses in life? Yes _____ No _____

If so, please comment:

3. How would you describe your health?

Excellent _____ Very good _____ Good _____ Fair _____ Poor _____

How did you arrive at the decision to consider see an Anti-Aging / Functional Medicine Specialist?

_____ Doctor _____ Self _____ Friend/family member _____ Other

Please Describe: _____



Describe your problems that lead you to this consultation:

What are your goals with this consultation?

Please write down any specific questions you may have.

How did you hear about us?

At a lecture: where?

Referral?

From a compounding pharmacy?

Do you presently get prescriptions at a compounding pharmacy?

If possible, bring in any recent lab work or other test results. Thank you!