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Please complete the Medical History Evaluation form **BEFORE** you first appointment. Please remember to bring your completed form with you at your first appointment. ****If you do not bring your completed Medical History Evaluation form, we will have to reschedule your appointment for another day****

You may also fax, email, or bring it to office ahead of time, but please bring another paper copy with you at the time of visit.

You also may want to bring to your appointment the following items:

1. Current or past prescriptions for hormones
2. Current supplements you are taking (so we can know the ingredients in them)
3. Previous lab results that might aid Infinite Wellness in your treatment

Infinite Wellness
FEMALE MEDICAL HISTORY EVALUATION FORM

Today's date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ Cell phone: _____

City: _____ State: _____ Zip Code: _____Home phone:_____

Email address: _____ Do you regularly check email? ___Yes ___No

Height: _____ Weight: _____ Occupation _____

Primary Care Physician/Provider:
Name: _____
Address: _____
Phone: _____Fax: _____

Alternate doctor:
Name: _____
Address: _____
Phone: _____Fax: _____

		How often and how much?
Do you use tobacco?	____Yes ____ No	_____
Do you use alcohol?	____Yes ____ No	_____
Do you use caffeine?	____Yes ____ No	_____
Do you exercise regularly?	____Yes ____ No	_____

Describe typical meals.
Breakfast - _____
Lunch - _____
Dinner - _____
Snacks - _____

Allergies: Please list all that apply.
Drugs: _____
Foods: _____
Other: _____
Please describe the allergic reaction when it occurred: _____
_____
_____

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

____ Heart disease	____ High cholesterol	____ High blood pressure	____ Cancer
____ Ulcers	____ Thyroid disease	____ Hormonal related issues	____ Lung conditions
____ Blood clotting problems	____ Diabetes	____ Arthritis/joint problems	____ Depression
____ Epilepsy	____ Headaches/migraines	____ Eye disease	____ Bipolar disorder
____ Chronic Fatigue Syndrome	____ Lyme disease	____ Schizophrenia	____ Infection: please list
____ Parkinson's disease	____ Irritable Bowel Syndrome	____ Traumatic Brain Injury	____ Fibromyalgia
____ Colitis	____ Fractures	____ Eating Disorder	____ Osteoporosis
____ Kidney trouble	____ Other: please list		

GYN/OB

How many pregnancies have you had? ____ How many children? _____ Ages: _____
Any interrupted pregnancies? _____ If yes, when: _____
Are you currently trying to get pregnant? _____ Yes _____ No
Have you had a hysterectomy? _____ If yes, when: _____ Ovaries removed? _____
Have you had a tubal ligation (tubes tied)? _____ If yes, when: _____
Have you had an endometrial/uterus ablation? _____ If yes, when: _____

Have you had any of the following tests performed?

Mammography	_____	Date: _____	Outcome: _____
PAP smear	_____	Date: _____	Outcome: _____
Bone Density	_____	Date: _____	Outcome: _____
Thyroid Panel	_____	Date: _____	Outcome: _____

At what age did your periods begin? _____
Since then, have you ever had what YOU would consider to be abnormal cycles? _____
If yes, please tell when and what symptoms you experienced? _____
_____
_____

When was your last period? _____ How many days did it last? _____
Are you sexually active? _____ Current birth control method (if applicable) _____
Do you have Premenstrual Syndrome (PMS)? _____ If yes, please explain symptoms:
_____
_____

Please list all **Over-The-Counter (OTC)** items you currently or occasionally use, such as antacids, pain relievers, acid blockers, laxatives, antihistamines, decongestants, cough suppressants, anti-diarrheals, sleep aids, etc. -
Do NOT include Nutritional Supplements
_____
_____
_____

Nutritional/Natural Supplements: Please identify and list the products you are using:
Vitamins (examples: multiple or single vitamins such as B complex, E, C, etc.)_____
_____
Minerals (examples: calcium, magnesium, chromium, etc.)
_____
_____
Herbs (examples: Ginseng, ginkgo biloba, etc.) _____
_____
Enzymes (examples: digestive formulas, CoEnzyme Q10, etc.)_____
_____
Nutrition/Protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.) _____
_____
Other: _____
_____

Current Hormone Therapies:

Name Strength Date Started How often per day

_____
_____
_____

List hormones previously taken:

Name Strength (if known) Date Started Date Stopped Reason for stopping

_____
_____
_____
_____

Current Prescriptions Medications:

Name Strength Date started How often per day

_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever used contraceptives? _____ Any problems? _____ If yes, please describe:

_____
_____
_____
_____

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

_____ Uterine Cancer Family member(s) _____
_____ Ovarian Cancer Family member(s) _____
_____ Fibrocystic Breast Family member(s) _____
_____ Breast Cancer Family member(s) _____
_____ Heart Disease Family member(s) _____
_____ Thyroid Disease Family member (s) _____
_____ Diabetes Family member(s) _____
_____ Osteoporosis Family member (s) _____
_____ Alzheimer's Family member(s) _____

Please write down any questions you have about Bio-identical Hormone Replacement (BHRT).

_____
_____

Adrenal Questionnaire

I have not felt well since

_____when_____
(Date) (Describe event, if any)

Predisposing Factors: Check you severity level: 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe

_____ I have experienced long periods of stress that have affected my well-being.
_____ I have had one or more severely stressful events that have affected my well-being
_____ I have driven myself to exhaustion
_____ I overwork with little play or relaxation for extended periods
_____ I have taken long term or intense steroid therapy
_____ I tend to gain weight, especially around the middle (spare tire)
_____ I have a history of alcoholism &/ or drug abuse
_____ I have environmental sensitivities
_____ I have diabetes (type II, adult onset, NIDDM)
_____ I suffer from post-traumatic distress syndrome
_____ I suffer from anorexia
_____ I have one or more other chronic illnesses or diseases

Energy Patterns

_____ I often have to force myself in order to keep going. Everything seems like a chore.
_____ I rely on caffeine and/or sugar to get through the day.
_____ I am easily fatigued
_____ I have difficulty getting up in the morning (don't really wake up until about 10 am)
_____ I suddenly run out of energy
_____ I usually feel much better and fully awake after the noon meal
_____ I often have an afternoon low between 3:00 – 5:00 PM
_____ I get low energy, moody, or foggy if I do not eat regularly
_____ I usually feel my best after 6:00 PM
_____ I am often tired at 9:00 – 10:00 PM, but resist going to bed
_____ I like to sleep late in the morning
_____ My best, most refreshing sleep often comes between 7:00 – 9:00 AM
_____ I often do my best work late at night (early in the morning)
_____ If I don't go to bed by 11:00 PM, I get a second burst of energy which often last until 1:00 – 2:00 AM

Thyroid Evaluation Form

Please indicate your severity level: **0 = None, 1 = Mild, 2 = Moderate, 3 = Severe**

SYMPTOMS

_____ Depression
_____ Dizziness
_____ Inability to lose weight
_____ Goiter (Enlarged thyroid)
_____ Cold Extremities
_____ Hoarseness
_____ Cold Intolerance
_____ Dry eyes
_____ Sleep disturbances
_____ Slow pulse rate
_____ Dry Hair
_____ Rapid heartbeat
_____ Hair loss
_____ Heart palpitations
_____ Brittle Hair/Nail
_____Puffy Eyelids/Face
_____ Dry Skin
_____ Acne
_____ Eczema
_____ Foggy Thinking/Forgetfulness
_____ Difficult Menses
_____ Elevated cholesterol
_____ Fatigue
_____ Constipation

When did these symptoms start?

_____

Is there a family history of ANY thyroid disease? Please list whom and what type (goiter, hypothyroidism, Graves' Disease, Hashimoto's Disease, etc.)

_____
_____

Symptom Survey

Instructions: Please enter the appropriate response number to each question in the columns below.

0 = None/Absent 1 = Mild or Rare 2 = Moderate 3 = Severe

Add an * (asterisk) if symptom is intermittent or "comes & goes".

_____ Vaginal Dryness
_____ Incontinence
_____ Poor memory/concentration
_____ Bone loss
_____ Dry skin/eyes
_____ Heart palpitations
_____ Tearful/Weepy
_____ Urinary Tract Infections

_____ High blood pressure/cholesterol
_____Irregular Menses
_____Depression
_____Anxiety
_____Low Libido
_____Hot flashes/night sweats
_____Headaches

_____ Loss of muscle tone
_____ Decreased stamina
_____ Bone loss
_____ Fatigue
_____ Incontinence
_____ Lack of motivation
_____ Aches and pain
_____Thinning skin
_____ Lack of sex drive

_____ Hair loss
_____ Uterine Fibroids
_____ Water retention
_____ Tender breast
_____ Fibrocystic breast
_____ Fibroids
_____ Weight gain
_____ Allergies/Sinusitis
_____ PMS
_____ Bone loss
_____ Sleep disturbances
_____Mood Swings
_____ Heavy bleeding/clots/painful cycles
_____ Irregular cycles

_____ Ovarian cysts
_____ Pain in nipples
_____ Mid -cycle pain
_____ Facial hair
_____ Scalp hair loss
_____ Insulin resistance
_____ Aggression/Irritability
_____ Excess body hair
_____ Acne/oily skin
_____ Increased facial or body hair

_____ Stress
_____ Morning Fatigue
_____ Evening Fatigue
_____ Sugar cravings
_____ Low blood pressure
_____ Arthritis/aches/pain
_____ Blood sugar imbalances
_____ Decreased immune system
_____ Fibromyalgia
_____ Allergies

_____ Insomnia/sleep disturbances
_____Tired but wired feeling
_____ Blood sugar imbalances
_____ Overwhelmed
_____Elevated triglycerides
_____ Irritable
_____ Panic attacks
_____ ADD/ADHD
_____ Compulsions/Addictions

Other: _____

What are you top 3 biggest concerns/symptoms?

1. _____
2. _____
3. _____