INTEGRATIVE WELLNESS CENTER, 525 GLEN CREEK RD NW, STE 230 SALEM, OR 97304 PH: 503-339-7376

FEMALE INTAKE HISTORY

Patient Name:_____ **Date of Birth:**_____

Current Concern(s)

_____
_____
_____
_____
_____

OB/GYN History

Age of your first menstrual cycle? _____
How many pregnancies have you had? _____ How many children do you have? _____
What are there ages?_____
Have you had an abortion? _____ Miscarriage? _____ D&C? _____

Still menstruating?_____(if no skip to below)
Date of Last Menstrual period_____
Are your periods painful? _____ How many days does the pain last? _____
How many days do you usually bleed? _____ How heavy? _____
What color is the blood? __ light red __ red __dark red __purple __brown
Is there clotting? _____
What are your premenstrual symptoms?_____
Do you get acne breakouts before or during your period? _____
Do your breasts become tender premenstrually? _____
How many days from one period to the next? _____
Have your cycles changed since they began? _____
Between periods, how much discharge do you have, if any? _____
Is it thin or thick? _____ Does it have a color? _____ An odor? _____

Have your cycles stopped?_____ Date of Last Menstrual period_____
When did you notice your cycles begin to change?_____
Are you experiencing any menopausal symptoms? What are they?_____
_____

Do you get yeast infections regularly? _____
Date of last pap smear _____ Have you had an abnormal pap smear? _____
Have you had a cervical biopsy, operation or cauterization? _____
Have you been diagnosed with uterine fibroids? _____ endometriosis? _____ PCOS?_____

Do you do a monthly breast self-exam?_____

What types of contraception do you or have you used in the past? How long did you use each? Any reactions or issues?
_____
_____

Current Medications

_____
_____
_____
_____
_____
_____

Allergies

_____
_____
_____
_____
_____
_____

Health Care Maintenance (Please list date of last procedure and result if known)
Mammogram: _____
Colonoscopy: _____
Dexascan: _____
Lipid Profile (Cholesterol): _____

Current Supplements

_____
_____
_____
_____
_____

Social History
Smoking: _____ No _____ Yes packs per day:_____ # years of use: _____
Alcohol : _____ No _____ Yes drinks per day:_____ drinks per week:_ _____
Illicit Drugs: _____ No _____ Yes type:_____ frequency: _____
Marital Status: _____single _____ married _____ divorced _____ widowed
School Completed: _____ high school _____ college _____ graduate _____ other_____
Occupation: _____ Hobbies: _____
Abuse History: _____ physical _____ sexual _____ verbal / emotional

Past Medical History

- ☐ Arthritis
- ☐ Asthma
- ☐ Alzheimer's Disease
- ☐ Autoimmune (MS, Lupus, etc)
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Drug Addiction/Alcoholism
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Migraine headaches
- ☐ Psoriasis
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ Mental Illness
- ☐ Other _____

Surgical, Injury and Hospitalization History
Please list all surgeries, injuries and hospitalizations and the dates on which they occured.

_____
_____
_____
_____
_____

Family History
Mom: _____ alive - current age: _____ _____deceased - age of death: _____ cause: _____
Dad: _____ alive - current age: _____ _____deceased - age of death: _____ cause: _____
Siblings:
_____ alive - current age: _____ _____deceased - age of death: _____ cause: _____
_____ alive - current age: _____ _____deceased - age of death: _____ cause: _____

Illnesses:		**Who? Deceased?**
High Blood Pressure	_____ No _____ Yes	_____
Diabetes	_____ No _____ Yes	_____
Heart Disease	_____ No _____ Yes	_____
Osteoporosis	_____ No _____ Yes	_____
Cancer	_____ No _____ Yes	_____
Stroke	_____ No _____ Yes	_____

Other?_____

Review of Systems

1.) Constitutional:
weight changes _____No _____Yes _____
fatigue _____No _____Yes _____

2.) Skin/Breast:
pain or mass in breast _____No _____Yes _____
nipple discharge _____No _____Yes _____
skin lesion _____No _____Yes _____

3.) Eyes:
vision problems _____No _____Yes _____

4.) ENT/Mouth:
hearing problems _____No _____Yes _____
sinus problems _____No _____Yes _____
dental problems _____No _____Yes _____

5.) Cardiovascular:
chest pain/shortness of breath _____No _____Yes _____
swelling in legs _____No _____Yes _____
palpitations of heart _____No _____Yes _____

6.) Respiratory:
wheezing or cough _____No _____Yes _____

7.) Gastrointestional:
nausea or vomiting _____No _____Yes _____
diarrhea or constipation _____No _____Yes _____
blood in stool _____No _____Yes _____

8.) Urinary:
pain with urination _____No _____Yes _____
blood in urine _____No _____Yes _____
incontinence _____No _____Yes _____

9.) Hematological:
frequent bruising _____No _____Yes _____
cuts do not stop bleeding _____No _____Yes _____
enlarged lymph nodes _____No _____Yes _____

10.) Psychiatric:
depression _____No _____Yes _____
anxiety _____No _____Yes _____

Exercise (Please check all that apply)

- ☐ No formal exercise
- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week

- ☐ 45 minutes or more duration per workout
- ☐ 30-45 minutes duration per workout
- ☐ less than 30 minutes duration per workout
- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight train
- ☐ Yoga
- ☐ Aerobic
- ☐ Other _____

Sleep (Please check all that apply)

- ☐ 8-10 hours per night
- ☐ 6-8 hours per night
- ☐ Less than 6 hours per night

- ☐ Undisturbed sleep
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

- ☐ Wake feeling rested
- ☐ Wake feeling tired

Signature of Patient: _____ **Date:** _____/_____/_____

Reviewed by Physician:
Date: _____/_____/_____ **Physician Signature:** _____