It's Alimentary Health History Addendum for WOMEN

Do you take care of others ahead of taking care of yourself? Yes No Maybe

Recent testing, if any:

Results of last PAP test __________________ Date of test __________________

Results of last mammogram_________________ Date of test __________________

Results of last thermography ________________ Date of test__________________

Results of last pelvic exam__________________ Date of exam ________________
(use this space to explain any atypical results)

Reproductive Health History:

Age at your first period______________________________

Date of first period __________________________________

Date of most recent period ___________________________

Are your periods regular? Yes No Days per Cycle _________________

How many days is your flow?

Is your flow light medium heavy?

Do you experience PMS? Yes No

If yes, please describe your symptoms:

Do you have painful periods? Yes No Debilitating

Do you have breast tenderness with your periods? Yes No

Do you have breast swelling with your periods? Yes No

Do you have any nipple discharge? Yes No

Do you have an absence of periods? Yes No

Are you perimenopausal? Yes No

If yes, please explain why you think so.

Are you menopausal? Yes No Date of last period _______________

If menopausal, do you have a lowered libido? Yes No

Do you have hot flashes or night sweats? (Please circle)

Do you have urinary frequency? Yes No

Do you have vulvar pain? Yes No

Have you had a sexually transmitted disease? _______________

Do you experience genital herpes? _______________________

Have you ever been pregnant? Yes No

Number of pregnancies _______________

Number of live births _________________-

Age (s) of your children _________________

Miscarriages __________________________

If yes, how many weeks pregnant were you? _______________

Ectopic pregnancies ________________________

Abortions ____________________________

Stillbirths ____________________________

Premature births ____________ Number of weeks of gestation _________

Contraception Use:

Have you used hormonal contraceptives: (please circle)

oral injected patch ring "morning-after" pill

Have you used an IUD? Yes No

If yes, when and for how long? ____________________________

What type of IUD? (please circle)

Copper hormone other _________________________

Please describe any symptoms you may have experienced with the use of any birth control methods, such as yeast infections, heavy/light bleeding, mood changes, weight gain, acne, sweet cravings, fatigue, depression, palpitations, inability to become pregnant after termination of contraception, etc.

Other hormonal use:

Have you used conventional hormonal replacement therapy? Yes No

If yes, please describe and specify dates of use.

Have you been tested for any of the following hormones, within the past two years? If yes, please circle.

DHEA
Cortisol
Testosterone
Estrogen
Progesterone
Thyroid

Please attach the test results, if possible. If not, please summarize the results for me as you recall them.

Have you used bio-identical hormones, such as DHEA, pregnenolone, progesterone, estrogen, testosterone, cortisol etc? Yes No

If Yes, what hormones, dosages, and for how long? Specify dates of use.

Are you currently using any fertility treatments? Yes No

If yes, please describe.

Pelvic health:

Have you had any ovarian cysts? Yes No

Do you have fibrocystic breasts? Yes No

Have you had any uterine fibroids? Yes No

Do you have endometriosis? Yes No Maybe

Do you have a diagnosis of PCOS (polycystic ovarian syndrome)? Yes No

If yes, have you had any treatment? Please describe.

Do you have vaginal infection(s)? Yes No

If yes, please describe.

Have you have any treatment or medication? Please describe.

Genital itching? Yes No

Genital discharge? Yes No

Do you have vaginal dryness? Yes No

Do you experience pain with intercourse? Yes No

Have you had a sexually transmitted disease? Yes No

Do you or your partner experience genital herpes? Yes No