Dr. Barbara Jennings
Natural Health In Real Life

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FEMALE HEALTH HISTORY QUESTIONNAIRE

GENERAL INFORMATION

Name: Today's Date:

Address _____ Phone # (h) _____ (c) _____

_____ Email Address _____

_____ Age _____ Date of Birth _____ Occupation _____

Height _____ Are you pregnant? Yes ____ No ____ Are you breastfeeding? Yes ____ No ____

Weight _____ Are you cyclic? Yes ____ No ____ Are you in Menopause? Yes ____ No ____

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Medication/Supplement/Food	Reaction

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes ____ No ____ If yes, please list: _____

_____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes ____ No ____ If yes, how many? _____

If yes, please list which kinds: _____

How long have you had these fillings? _____

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes ____ No ____

Have you had any dental work done in the last 12 months? Yes ____ No ____

MEDICATIONS AND SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?

Yes _____ No _____ If yes, please describe: _____

SLEEP/REST

Average number of hours you sleep ☐ > 10 ☐ 8 – 10 ☐ 6 – 8 ☐ < 6

Do you have trouble falling asleep? Yes ____ No ____

Do you rested upon awakening? Yes ____ No ____

Do you have problems with insomnia? Yes ____ No ____

Do you snore? Yes ____ No ____ Explain: _____

LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? Yes ____ No ____ How many years? _____ Packs per day: _____

If yes, what type? Cigarette _____ Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____

Previous smoking: How many years? _____ Packs per day: _____

Are you exposed to 2nd hand smoke? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 oz wine, 12oz beer, 1.5 oz spirits*

None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____ > 10 _____

Previous alcohol intake? Yes _____ (Mild _____ Moderate _____ High _____)

CAFFEINE INTAKE

How many cups of coffee per day? None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____

How many cans of soda per day? None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____

Is the soda you drink, diet soda? Yes _____ No _____

PREGNANCY HISTORY (Check box if yes and provide number of)

☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal deliveries _____

☐ Miscarriage _____ ☐ Abortion _____ ☐ Living children _____

☐ Post partum depression ☐ Toxemia ☐ Gestational diabetes

☐ Baby over 8 pounds ☐ Breastfeeding For how long? _____

FOR THE CYCLIC-AGE WOMAN

Age at 1st period: _____ Frequency: _____ Length of period: _____ Pain: Yes ____ No ____

Clotting: Yes ____ No ____ Has your period skipped? _____ For how long? _____

Last Menstrual Period: _____ How many days is your current cycle? _____

Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?

☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Have you ever used hormonal contraception? Yes _____ No _____ If yes, when _____

Use of hormonal contraception: ☐ Birth control pills ☐ Patch/injection ☐ Nuva Ring

Are you using the pill now? Yes _____ No _____ Did taking the pill agree with you? Yes _____ No _____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes _____ No _____

Date of last Mammogram _____ Breast Biopsy/Date _____

Last PAP Test _____ Normal _____ Abnormal _____

Other information for us to know: _____

FOR THE WOMAIN IN MENOPAUSE

Age at onset of menopause: _____ Year of onset of menopause: _____

When you were cycling, would you consider your cycle regular? Yes ____ No ____

If no, why?: _____

When you were cycling, what was your typical menstrual flow? Light _____ Medium _____ Heavy _____

Have you had a hysterectomy? Complete (ovaries and uterus) _____ Partial (uterus only) _____

Date of hysterectomy _____ Reason for hysterectomy: _____

Date of last Mammogram _____ Breast Biopsy/Date _____

Date of last Bone Density _____ Results: ☐ High ☐ Low ☐ Within normal range

Are you in menopause? Yes _____ No _____ Age at Menopause _____

Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin ☐ Progesterone

☐ Provera ☐ Other _____

How long have you been on hormone replacement? _____