Women's Integrative Health

We look forward to your first visit in our office! Please find a quiet moment to complete this questionnaire. We ask that you submit it 3 business days prior to your appointment. This allows us time to prepare for your visit and makes our time together much more productive! We have carefully chosen these questions to address all aspects of your health. Your answers will help us to work with you in a way that best meets your health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so at your appointment.

Name: _____Today's Date: _____

Age: _____ Date of Birth_____/____/_____ SS # _____

Occupation: _____

Phone Number Home (____)_____Cell (___)_____

Work (____)_____

Permission to leave voice mail message? _____ Home _____ Work _____Cell

Email Address _____

Mailing Address _____

_____

Emergency Contact:_____Relationship _____

Emergeny Phone # (____)_____

Insurance Co.: _____ Name of primary card holder: _____

Group Number: _____ ID Number: _____

***Insurance Claims**: We do not participate in any insurance plans or Medicaid and have opted out of Medicare. We will provide you with documentation that you can submit to your plan if you are eligible for out of network benefits. We are not responsible for any billing issues between you and your insurance carrier. Please call your plan to determine what benefits you may or may not be eligible for prior to having your visit with us. Why do we collect insurance information? We do this because many of the labs we order will be covered by your insurance.*

How did you hear about our practice? _____

Who is your primary care provider? _____

Who is your ob/gyn or midwife? _____

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831

(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com

Women's Integrative Health

What brings you to the office today?

_____

_____

_____

_____

_____

_____

If you had three wishes for today's visit, what would they be?

1. _____

2. _____

3. _____

When did you last feel well?_____

Please list the **healthcare providers** who have treated you recently:

Name	Profession/Specialty	Telephone #	Dates of treatment From	To

What **medications** are you currently taking? This includes over-the-counter medications

Name	Dose or quantity per day	When did you start it?

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831

(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com

Women's Integrative Health

What **supplements** are you currently taking? This includes vitamins, homeopathic and herbal remedies, other nutritional supplements.

Name	Dose or quantity per day	When did you start it?

Do you have **ALLERGIES** to medications or environmental triggers? _____YES _____NO
If yes, please describe_____

_____

Do you have **food or chemical sensitivities** or sensitivities: _____YES _____ NO
If yes, please describe_____

_____

Please list any **hospitalizations, surgeries, or significant injuries** you have had:

Reason for hospitalization or surgery	Date

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831

(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com

Women's Integrative Health

Ob History: Check all that apply and enter # if applicable:

Total # of Pregnancies _____ □ Living children _____ □ Adopted Children _____
□ Vaginal Deliveries _____ □ Surgical Abortions _____ □ Breast feeding
□ C-Section Deliveries _____ □ Medication Abortions _____ □ Preeclampsia
□ Miscarriages _____ □ Preterm Delivery _____ □ Gestational Diabetes
□ Ectopics _____ □ Post Partum Depression □ Baby over 8 pounds

Gyn History: age at first period: _____ when was last period? _____ period frequency: _____

Periods (check all that apply):

_____ too long (number of days): _____
_____ heavy (number of pads a day): _____
_____ clotting
_____ painful (take medicine?): _____
_____ skipped periods
_____ mood changes
_____ breast tenderness

Use with periods (check all that apply):

_____ tampons
_____ pads
_____ organic disposable
_____ cotton reusable
_____ menstrual cups
_____ menstrual underwear

Do you have sex with men, women, or both: _____
What gender do you identify as? _____ What pronoun do you prefer? _____

Contraception History:

What contraception do use now? _____
What contraception have you used in the past?

_____ Birth control pills
_____ patch
_____ ring
_____ 3 month injection
_____ rod/Implant
_____ condoms
_____ IUD (if yes, which one)
  _____ Copper
  _____ Mirena
  _____ Kyleena
  _____ Skyla
_____ tubal ligation/hysterectomy
_____ Essure/coils
_____ partner sterilization
_____ withdrawal
_____ timed intercourse/natual family planning
_____ abstinence
_____ same sex partner, never needed it

Gyn Problems:

_____ pelvic pain
_____ fibroids
_____ endometriosis
_____ adenomyosis
_____ polyps
_____ infertility
_____ polycystic ovarian syndrome
_____ irregular periods
_____ absence of periods
_____ abnormal bleeding
_____ ovarian cysts
_____ cancer of cervix/ovary/uterus
_____ molar pregnancy
_____ abnormal pap smear
_____ colposcopy
_____ warts
_____ LEEP, cryo, or conization
_____ chlamydia or gonorrhea
_____ herpes
_____ Pelvic Inflammatory Disease
_____ DES exposure
_____ uterine anomaly
_____ frequent vaginal infections

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831

(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com

Women's Integrative Health

Please describe any *additional* Gyn problems that you have or have had: _____

_____

Childhood: Do you recall lots of: □ sugar/candy □ ear infections □ strep throat
□ frequent antibiotics □ stomach aches □ fussy baby □ mono □ other childhood illness
□ significant injuries: _____

Dental: check all that apply: □ floss regularly □ bleeding gums □ bad breath
□ many cavities □ silver/mercury fillings □ filling removals □ root canals □ implants

Preventive Screenings:
□ Full Physical Exam _____ □ Mammogram _____
□ Colonoscopy _____ □ Pap Smear/HPV _____
□ EKG _____ □ Bone Density _____

Relationships: □ Single □ Married □ Long Term Partner □ Divorced/Separated
Spouse/Partner's Name and occupation:_____

Child's Name	Age	Gender

Who do you live with: _____
_____

Are you satisfied with your **personal relationships**?_____YES _____NO

Have you ever been the victim of emotion, physical, or sexual abuse? _____ YES _____NO
If yes, would you like to share? _____
_____

Have you been in therapy before? _____ Past _____ Present _____ Never

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831
(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com

Women's Integrative Health

Medical History Please check the health problems that apply to each family member	Self	Grandparent	Father	Mother	Sibling	Child	Check all **symptoms** that apply ***currently***	√
							Memory problems, "brain fog"	
							Fatigue or Loss of Energy	
							Generalized Weakness	
							Dizzy Spells, Fainting Spells or Blackouts	
							Tremor or tingling or numbness	
							Cold hands or feet	
Alcoholism/Drug addiction							Frequent Headaches	
Allergies/Hayfever							Vision or Hearing Disturbances	
Anemia							Nosebleeds	
Arthritis: Osteo or Rheumatoid							Sinus pains, Nasal congestion, post nasal drip	
Anxiety							Frequent throat clearing or hoarseness	
Autoimmune:							Weight loss or gain	
Asthma							Swollen Glands	
Blood clots or Bleeding Disorders							Frequent infections	
Cancer:							Shortness of Breath	
Chronic Fatigue Syndrome							Frequent Coughs, Wheezing	
Colitis or Crohn's							Palpitations, Chest Pains, Rapid Heartbeat	
Celiac Disease							Anxious Feeling in Chest or Stomach	
Cholesterol problem							Poor Appetite or nausea	
Depression							Indigestion, foods repeating	
Diabetes or Insulin Resistance							Abdominal Pain	
Eating Disorder							Abdominal Bloating, Passing gas	
Emphysema, COPD							Constipation, Use of Laxatives	
Eye disease:							Diarrhea, Bloody Stools	
Fibromyalgia							Undigested food in stool	
Gout							Rectal Pain, Itching, Irritation	
Heart Disease:							Hemorrhoids, Anal Fissures	
High Blood Pressure							Urinary Incontinence	
HIV, AIDS							Burning with urination	
Irritable Bowel Syndrome							Frequent urination	
Kidney Disease/Stones							Breast pain or discharge	
Liver Disease, Hepatitis							Breast lumps	
Lupus							Pain with sex	
Lyme Disease							Lack of interest in sex or inability to orgasm	
Migraine Headaches							Irregular or painful periods	
Mono/Epstein Barr							Premenstrual tension/mood swings	
Multiple Sclerosis							Vaginal Itch or odor	
Musculoskeletal pain:							Vaginal dryness	
Overweight							Hotflashes or night sweats	
Osteoporosis							Swollen or painful legs	
Parkinson's Disease							Back Pain, Sciatica	
Reflux or Peptic Ulcer							Joint Pain, Joint Swelling	
Seizures							Skin discoloration, rashes, sores,	
Skin problem:							Insomnia, proglems with sleep	
Sleep Apnea							Fears or Phobias	
Sinus problems:							Anxiety, Nervousness, or Panic Attack	
Stroke							Angry, Irritable, Impatient, Critical	
Suicide (or attempted)							Sadness, Grief, Depression	
Thyroid Disease							Other:	

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831

(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com

Women's Integrative Health

Other Health Problems not listed above: _____
_____
_____
_____
_____

In your work/home environment have you been **exposed** to:

□ chemicals	□ radiation	□ electromagnetic radiation
□ heavy metals	□ mold	□ photography chemicals
□ herbicides	□ bug spray	□ hair/nail coloring agents
□ pesticides	□ lead paint	□ oil based paint
□ horse barns	□ fumes	□ time on golf courses
□ asbestos	□ solvents	□ furniture refinishing
□ home renovations		□ sports on turf or fields with pesticides

Are you **sensitive** to: □ caffeine □ MSG □ anesthetics □ red wine □ sulfites □ preservatives □ perfume □ cigarette smoke □ auto exhaust □ other: _____

Do you consume any of the following?

	Yes	No	If yes, how much per week	If quit, when
Beer or wine				
Liquor				
Tobacco products				
Marijuana, cocaine or other drugs: (specify)				
Coffee, soda or other drinks with caffeine				

Do you have or had a problem with any of the substances listed above?_____YES____NO
If yes, please explain: _____

What **foods** do you eat on a regular basis?

Breakfast foods	
Lunch foods	
Dinner foods	
Snack foods	
Foods you crave	

Women's Integrative Health

How many of your meals each week are prepared in a restaurant? _____
Do you follow any particular diet (vegan, paleo, etc.)? _____
What foods do you avoid ? _____
Do you read food labels? _____Yes _____ No
Have you ever done an elimination diet? _____ Yes _____No
Have you ever had a nutrition consult? _____Yes _____ No
Are you interested in □ losing or □ gaining weight? _____Yes _____No
What is your current weight? _____ Goal Weight? _____ Current height? _____

Check all of the factors below that apply to you:

□ Fast Eater □ Poor snack choices □ Travel frequently
□ Erratic Eating pattern □ Love to eat □ Dislike Healthy food
□ Late Night eating □ Binge eater □ Emotional Eater

What **exercise activities** do you do in a typical week?

Activity Type	Times per week	Minutes per time
Cardio:		
Weights:		
Stretching:		
Yoga/Pilates/other:		

SLEEP: Time you go to bed: _____Time you wake up:_____

Do you feel that you get enough sleep?	Yes	No
Do you have difficulty falling asleep?		
Do you wake up and can't get back to sleep?		
Do you feel rested in the morning?		
Is sleep a problem for you?		

Is **stress** a significant problem for you? _____ YES _____ NO

Do you think you handle your **stress** well? _____ YES _____NO

What are your greatest sources of **stress**? □ family □ work □ social □ finances □ health

□ other: _____

_____

_____

What activities do you do to help with **stress**? Check all that apply: □ Yoga □ Meditation

□ Tai Chi □ Breathing □ Prayer □ Therapy □ Other: _____

_____

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831

(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com

Women's Integrative Health

What are your greatest sources of **comfort** ? □ spouse □ family □ friends □ pets □ religion □ other: _____

_____

_____

What **activities** to you do for fun? _____

_____

_____

Are you currently a **student**?_____YES _____NO
If yes, where?_____

What is your **job or occupation?** _____
Are you satisfied with your work?_____YES _____NO
Please describe:_____

_____

_____

Is there anything about your **work that negatively affects your mental or physical health**?

_____

_____

_____

Is there **any other information** about you that you feel is important?

_____

_____

_____

_____

_____

_____

2 Greenwich Office Park, Suite 300
Greenwich, CT 06831

(p)203-900-4194 (f) 203-405-0803
womensintegrativehealth.com