Health by Design Natural Clinic
Female Health Questionnaire

Name _____ **Date** _____
Address _____ **City** _____ **Zip** _____
Home _____ **Cell** _____ **Email** _____
Age _____ **Height** _____ **Weight** _____ **DOB** ____/____/____

Office Use Only
R S: _____

Main complaint that brought you here today: _____

_____

Supplements/Medications

What supplements are you taking and for what reasons? _____

_____

What medications are you taking and for what reasons? _____

_____

Are you allergic to any medicines: Y/N If Yes Please List _____

_____

Medical History

Have you had any surgeries? Y/N……..If yes, What/ When? _____
History of blood sugar imbalances Y/N…….Diabetes ____ _____ Hypoglycemia _____
Please list any diseases or conditions you have been diagnosed with: _____

_____

Menstrual Cycle

Date of last period: ____/____/____ Hysterectomy? Y/N Was cycle regular? Y/N
Length of period? (I.e. 5 days) _____ Do you still feel symptoms of a cycle? Y/N _____

Pregnancy

Have you ever been pregnant? Y/N If yes, number of children: _____
Did you have problems with the Pregnancy? Y/N If yes, what: _____

Exercise

Do you exercise? Y/N How often? _____ Times per Day / Week / Month
What sports or physical activities do you participate in, and at what level? _____

_____

Sleep

What time do you usually go to sleep _____ Arise_____ Do you have problems getting to sleep? Y/N
How many times do you wake during the night _____What times _____
Do you fall right back to sleep or lie awake for a while _____
When you wake up are you…Rested / Tired Do you have…dreams / nightmares? Are they vivid? Y/N

Please select any condition you have had and rate current conditions on a scale of 1 – 10 (10 being the worse amount of discomfort, 1 being the least.)

Adrenal Function

Depression	Anxiety	Easily Stressed
Hyperactivity	Weight gain	Headaches with exertion or stress
Loss of memory	Blood sugar imbalances	Slow starter in the morning
Insomnia	Brittle nails	Excessive perspiration
Afternoon fatigue	Salt craving	Wake up tired after 6 or more hours of sleep
Worry without cause	Lack of consistent energy	

Female

Hot flashes	Night sweats	Irritability with cycle
Emotional mood swings	Easily upset	Brittle nails
Hair loss	Thinning hair	Weight gain
Acne	Frequent Headaches	Migraines
Vaginal dryness	Change in libido	Fibrocystic breasts
Breast tenderness	Endometriosis	Ovarian pain
Ovarian cysts	Hysterectomy	Uterine Ablation
Post-menopausal	Fluid retention	Abdominal bloating
Excessive flow during cycle	Clotty flow during cycle	Excessive cramps during cycle
Pain during intercourse	Shrinking breasts	Mental fogginess
Facial hair growth	Lack of menstruation	Alternating menstrual cycle lengths

Digestion

Excessive belching	Lower bowel gas	Stomach ache or pain
Nausea	Heartburn	Discomfort or fatigue after eating specific foods
Vomiting	Use of antacids	Undigested food in stools
Bad breath	Bloating or burping	Feeling tired or sluggish after meals

Elimination

Frequent use of laxatives	Diarrhea	Less than 1 full bowel movement daily
Hard, dry, or small stool	Lower bowel gas	Alternating constipation and diarrhea

Intestinal Integrity

Yeast infections	Coated tongue or "fuzzy" debris on tongue
Use of antibiotics	Intolerance to sugars and starches
Lower abdominal bloating	Passing large amounts of odorous gas

General Symptoms

Bruise easily	Hair loss
Puffy eyes	Brittle hair
Dark circles around eyes	Gray hair
Itchy or blotchy skin	Frequent colds/flu
Memory loss long term	Memory loss short term
Frequently hot	Frequently cold

Informed Consent

Our services and products and the claims made have not been evaluated by the FDA, and are not intended to diagnose, treat, cure or prevent any disease. So that we may accommodate all clients during their scheduled appointment times, we kindly request a 24 hour notice for re-scheduling appointments. We must impose a $50 cancellation fee if 24 hour notice is not given. I have read and understand the above information.

Client Signature:_____ Date:_____

FOR OFFICE USE ONLY:

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