Heights Holistic Wellness New Patient- Women's Intake Form

Reason for Visit:
Menopausal Symptoms
Hormone Imbalance
Sexual Dysfunction
Vaginal/Pelvic Pain
Contraception Management

Has a PCP
Yes
No
Name of PCP

_____

Months since last visited PCP
Less than 1
1 to 6
7 to 12
More than 12 months
Month and year of last Pap smear

_____

Last Menstrual Period

_____

Length of Period

_____

Currently on Hormone Replacement Therapy?

_____

Personal History of Breast Cancer
Yes
No
1st Degree Family (Mother, Sister, Daughter) History of Breast Cancer
Yes
No
Last Mammogram & Result (If over 40)

_____

Birth control methods patient is using

_____

- New prescription needed _____
- Additional information _____

_____

How often uses condoms during sex
Every time I have sex
Frequently

Rarely
Weeks since last Depo-Provera shot;
Less than 1
1 to 4
5 to 8
9 to 12
More than 12
I'm not sure
Type of IUD
Liletta (levonorgestrel)
Mirena (levonorgestrel)
ParaGard (copper)
Skyla (levonorgestrel)
Other
I'm not sure
Planning pregnancy in next 12 months
Yes
No
I'm not sure
Fitness activities
Description of diet and any nutritional concerns

_____

_____

Medical History

RECENT MEDICAL

SURGICAL HISTORY

Recent medical problems

Recent surgeries

SOCIAL HISTORY

SEXUAL HISTORY
Patient has sex with men, women, or both
Men
Women
Both
Types of sex
Vaginal
Oral

Anal

Number of sexual partners in past year

_____

Number of sexual partners in lifetime

_____

Sexual Concerns

Desire/Libido Issues
Arousal/Lubrication Issues
Pain with Sex
Difficulty Achieving Orgasm

Decreased Sexual Desire Screener

In the past, was your level of sexual desire or interest good and satisfying to you?
Yes
No

Has there been a decrease in your level of sexual desire or interest?
Yes
No

Are you bothered by your decreased level of sexual desire or interest?
Yes
No

Would you like your level of sexual desire or interest to increase?
Yes
No

Please circle all the factors that you feel may be contributing to your current decrease in sexual desire or interest:

a. An operation, depression, injuries, or other medical condition
b. Medications, drugs, or alcohol you are currently taking
c. Pregnancy, recent childbirth, menopausal symptoms
d. Other sexual issues you may be having (pain, decreased arousal, or orgasm)
e. Your partner's sexual problems
f. Dissatisfaction with your relationship or partner
g. Stress or fatigue
H- None

Other social history behaviors

Drink alcohol
Exchange sex for drugs or money
Smoke cigarettes or another form of tobacco
Use recreational drugs
None of the above

Drinks per typical week

Less than 1
1 to 2
3 to 7
8 to 14
15 to 21

22 to 28
29 to 35
More than 35

Drank 5 or more drinks on any one occasion in past month

Yes
No

CAGE questions

Felt you needed to cut down on your drinking
Been annoyed by people criticizing your drinking
Felt guilty about drinking
Felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover
None of the above

Forms of tobacco smoked

Cigarettes
Cigars
Pipe
Other

Years of tobacco smoking

Less than 1
1 to 5
6 to 10
11 to 15
16 to 20
21 to 30
More than 30

Cigarettes per day

5 (quarter pack) or fewer
10 (half pack)
20 (one pack)
30
40 or more

Cigars per week

Less than 1
1 to 2
3 to 7
More than 7

Frequency of pipe smoking

Once a week or less
A few times a week
Daily
Many times a day

Recreational drugs used

Alkyl nitrites (Poppers)
Benzodiazepines
Cocaine or crack

Heroin
LSD
Marijuana
MDMA (Ecstasy or Molly)
Methamphetamine (Crystal, Speed, or Ice)
Mushrooms
Nitrous
Other

History of intravenous drug use

Yes
No
Prefer not to say

Intravenous drug use in past year

Yes
No

MEDICATIONS, SUPPLEMENTS, CAM

Regularly taking or using medications

Yes
No

Medications taken

_____
_____

Regularly taking supplements

Yes
No

Supplements taken

_____
_____

Types of complementary and alternative medicine used

Acupuncture
Ayurveda
Chiropractic
Cupping
Homeopathy
Naturopathy
Other
None of the above

ALLERGIES

Allergic to medications

Yes
No

Medication allergies

_____
_____

REVIEW OF SYSTEMS

ROS - General

Fatigue
Loss of energy
Night sweats that soak the sheets
Unintentional weight gain
Unintentional weight loss
None of the above

ROS - Eyes

Blurred vision
Double vision
Eye pain or irritation
Floaters
Need for corrective lenses
Spots in front of your eyes
None of the above

ROS - ENT

Bad breath
Bleeding gums
Dizziness
Headaches
Hearing loss
Hoarseness
Nasal congestion
Nose bleeds
Ringing in ears
Sinus pain
Sore throat
Toothache
None of the above

ROS - Respiratory

Chest congestion
Choking
Cough
Noisy breathing
Shortness of breath
Snoring
Wheezing
None of the above

Cough is productive

Blood
Mucus (phlegm)
None of the above

ROS - Cardiovascular and breast

Awakening due to shortness of breath
Breast lump
Chest pain
Decreased exercise tolerance

Difficulty breathing when lying down
Heart fluttering or racing
Leg swelling
Lightheadedness
Nipple discharge
Pain in buttocks or legs with exercise
Passing out
Sensitivity of hands or feet to temperature changes
None of the above

ROS - Gastrointestinal

Belching
Bloating
Black, tarry stools
Bloody stools
Constipation
Diarrhea
Difficulty swallowing
Heartburn
Indigestion
Nausea
Sour taste in the mouth
Stomach or abdominal pain
Vomiting
None of the above

Appearance of vomit

Bile (greenish brown)
Blood
Clear
Coffee grounds
Food
Yellow
Other

ROS - Genitourinary (female)

Bloody urine
Change in menstrual period
Decline in sexual desire
Difficulty in sexual function
Frequent urination
Frequent urge to urinate
Hot flashes
Nighttime urination
Pain with urination
Painful intercourse
Painful periods
Pelvic pain
Troublesome symptoms before or during periods

Urinary incontinence
Vaginal discharge
Vaginal dryness
Vaginal irritation
Vaginal pain
Vaginal pressure
Vaginal redness
Vaginal wall weakness or protrusion
None of the above

ROS - Hematologic/lymphatic

Easy bruising
Painful or swollen lymph nodes
Unusual bleeding
None of the above

ROS - Musculoskeletal

Back or neck injury
Limb or joint deformity
Limb or joint pain
Limb or joint swelling, stiffness, or redness
Loss of muscle bulk
Muscle spasm or twitching
Muscle weakness
Recurring back or neck pain
Sciatica
None of the above

ROS - Neurologic

Altered consciousness or blackouts
Arm or leg numbness or tingling
Arm or leg weakness
Memory difficulty
Seizures
Tremors or shakiness
Unusual clumsiness
None of the above

ROS - Psychiatric

Anxiety
Depression
Difficulty concentrating
Mood swings
Panic attacks
None of the above

ROS - Skin

Changing or itchy moles or freckles
Itchiness
Rash or other concerning skin lesions
Unusual dryness

None of the above

ROS - Endocrine

Intolerance to cold
Intolerance to heat
Thinning hair
Thinning nails
Unusual thirst
None of the above

ROS - Allergic/immunologic

Hives
Itchy eyes
Runny nose
None of the above

ANYTHING ELSE

Anything else patient would like to share?

_____
_____
_____
_____