



**Primary Health Concern**

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**Other Health Concerns**

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**Your Medical History**

List major events and dates that they occurred (include marriages, births, deaths, divorce, accidents, major illness, surgery, job changes, miscarriages, and anything else you feel greatly impacted your life or health):

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Were you breastfed as a baby?  Yes  No For how long? \_\_\_\_\_

List any medications (prescription and over-the-counter), vitamins, and/or supplements you are currently taking:

**Supplement / Medication**

**Reason you are taking**

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86 Kennedy Drive Severna Park, Maryland 21146 410-271-3935

**Circle any of the following conditions that you are experiencing:**

Diabetes, Heart disease, High blood pressure, Stroke, Bleeding/Clotting tendency, Nervous illness, Addiction/Alcoholism, Arthritis, Asthma, Allergies, Inflammatory bowel disease, Ulcers, Lyme disease, Seizures, Cancer, Gall Stones, Venereal disease, Kidney disease or stones, Autoimmune illness, Tuberculosis, Thyroid problem, Chronic fatigue, Fibromyalgia, Anxiety/Depression, Herpes, Chronic obstructive pulmonary disease (COPD), Rheumatic fever, HIV/AIDS, Anemia, Hepatitis, Osteoporosis, Mononucleosis, Parasites

Other conditions not listed above: \_\_\_\_\_

When is the last time you had your Vitamin D level checked? \_\_\_\_\_

When is the last time you had blood work? \_\_\_\_\_

What did the blood work indicate? \_\_\_\_\_

**Do you crave particular foods?**  Yes  No

Which ones? \_\_\_\_\_

When do you typically crave them? \_\_\_\_\_

**List any foods that you avoid due to allergies, sensitivities, religious, or other reasons:**

<u>Food</u>	<u>Allergy</u>	<u>Sensitivity</u>	<u>Religious Belief</u>	<u>Other Reason</u>
_____				
_____				
_____				

Do you Use:	<u>Now</u>	<u>Past</u>	<u>Frequency</u>	<u>Never</u>
Tobacco				
Alcohol				
Coffee				
Soft Drinks				

Do you Exercise?  Yes  No      Number of times/ week: \_\_\_\_\_

Type of Exercise: \_\_\_\_\_

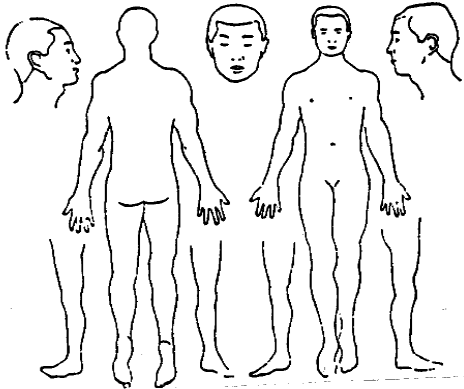
Your current weight \_\_\_\_\_

Your ideal weight \_\_\_\_\_

Have you lost or gained more than 10 pounds in the past year?  Yes  No

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**Please mark all areas of pain on the diagram**



**Urination:** Please circle any of the following symptoms you are currently experiencing:

Burning      Urgent      Retention      Scanty      Profuse      Dribbling

Number of times you get up per night to urinate \_\_\_\_\_

**Bowel Movements:** Frequency: \_\_\_\_\_

Stools:    Undigested food    Blood    Mucous

Consistency:    Well-formed    Hard    Loose    Alternates

**Lifestyle:**

List three cleaning products that are typically used in your home (ex., Windex, Tilex, Clorox, etc.)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Do you use chemical fertilizer on your lawn?  Yes  No

Type of water you drink? (Tap, Britta, Reverse Osmosis, Bottled, etc.) \_\_\_\_\_

On a scale of 1-10, how stressed do you feel? 10=Extremely Stressed, 1= Not stressed at all \_\_\_\_\_

Do you practice yoga?  Yes  No

Do you meditate?  Yes  No

On a scale of 1-10, how would you rate your relationship with your partner?

10=Excellent, 1= Very Unfulfilling \_\_\_\_\_

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**Women Only:**

At what age did you get your first period: \_\_\_\_\_ Date of last menstrual cycle? \_\_\_\_\_

Are you currently on the Pill?  Yes  No

Have you ever been on the Pill?  Yes  No How long? \_\_\_\_\_

What type of birth control do you use? \_\_\_\_\_

Are you pregnant now?  Yes  No

Number of days from the start of one period to the start of the next: \_\_\_\_\_

Are your menstrual cycles spaced regularly?  Yes  No

Average number of days of flow: \_\_\_\_\_ Flow is:  Light  Normal  Heavy

Color is:  Pale  Dark Red  Bright Red  Brown

Are blood clots present?  Yes  No

Does your period cause you pain or cramping?  Yes  No

When?  Before  During  After Period

Do you experience any of the following before your period each month?

Water retention  Breast tenderness or swelling  Mental depression

Irritability  Food cravings  Migraines  Other \_\_\_\_\_

Do you ever bleed or spot between periods?  Yes  No

Do your bowel movements become loose at the beginning of your period?  Yes  No

Do you get yeast infections?  Yes  No How often? \_\_\_\_\_

Do you chart your basal body temperature?  Yes  No

Have you experienced menopause?  Yes  No When? \_\_\_\_\_

If you are experiencing menopausal symptoms, please describe: \_\_\_\_\_

\_\_\_\_\_

Do you feel as if your hormones are "off?"  Yes  No

Pregnancies (please include losses and terminations):

Year	Vaginal or C section	Complications or conditions of note
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Women Seeking Fertility Help**

Number of months trying to conceive: \_\_\_\_\_

Have you been given a diagnosis for your fertility?     Yes     No

Diagnosis \_\_\_\_\_

Are you using Assisted Reproductive Technology?     Yes     No

Which Clinic? \_\_\_\_\_

# of IUIs \_\_\_\_\_                      # of Pregnancies \_\_\_\_\_

# of IVFs \_\_\_\_\_                      # of Miscarriages \_\_\_\_\_

Other: \_\_\_\_\_                      # of Live Births \_\_\_\_\_                      Age of your child(ren) \_\_\_\_\_

Upcoming fertility procedures: \_\_\_\_\_

**Men Only:**

Have you been diagnosed with prostate problems?     Yes     No

Have you ever experienced any of the following?

Blood in semen?     Yes     No                      Burning on ejaculation?     Yes     No

Low Libido?     Yes     No                      Vasectomy?     Yes     No

Pain or swelling of testicles?     Yes     No                      Penis discharge?     Yes     No

Painful orgasm/intercourse?     Yes     No                      Impotence?     Yes     No

Do you experience premature ejaculation?     Yes     No

Additional things you'd like to mention related to health or well-being not previously covered:

Thank you for taking the time to fill out this form thoroughly. It will help to serve you better.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_