

CLIENT HISTORY FOR WOMEN

Your answers on this form will help me understand your health concerns better prior to your first appointment. Best estimates are fine if you cannot remember specific details.

Please print the form and fill it out. Then either scan the form and email it to me at drgedde@natural-hormone-balance.net, or fax it to 775-766-9681. **Thank you!**

Date _____
Last Name _____
First Name _____
Street Address _____
City State Zip _____
Phone _____ Home Work Cell (circle one)
Email Address _____
Age _____

How would you rate your general health? Excellent Good Fair Poor

Chief Concern

What is your main health concern?

How long have you had this concern?

Medications

What medications are you currently taking?

Please list brand or generic name, dose, and how often you take the medication.

What supplements are you taking? Include herbal, vitamin and mineral supplements.

Are you allergic to any medications? Please specify:

Gynecologic History

Do you have your uterus and ovaries? Yes No

If no, please give details _____

Please check each condition that you have had, or that you have now. Please note when you had the condition, any treatment you had, and whether it is a concern now.

- Premenstrual syndrome _____
- Lumpy or fibrocystic breasts _____
- Breast biopsy or lumpectomy _____
- Cervical dysplasia (abnormal Pap smear) _____
- Uterine fibroids _____
- Endometriosis _____
- Ovarian cysts _____
- Polycystic ovary syndrome _____
- Infertility _____

Have you had breast, ovarian or uterine cancer? No Yes

If yes, please give details _____

Menstrual History

- Date of your last menstrual period _____
- Age when your periods started _____
- How regular are/were your periods? _____
- How frequent are/were your periods? _____
- How long are/were your periods? _____
- How heavy or light were they? _____
- Have cramps been a problem? _____
- Age at menopause if applicable _____

Obstetric History

Please give the year of each pregnancy and the outcome of each (delivery, miscarriage, abortion)

Any complications of pregnancy or childbirth?

Have you ever used birth control pills? If so, when and for how long?

General Medical

Please list any chronic illness (diabetes, heart disease, asthma etc.) and how long you have had it:

How much have you used antibiotics in your life? Little or none Significant A lot

Please give details _____

Do you have low bone density? No Yes

If yes, please give details _____

Do you have or believe you may have:

Multiple chemical sensitivities Fibromyalgia Chronic fatigue syndrome

Please list any surgeries (type and year): _____

Please list any significant accidents or injuries: _____

Please note any treatment for psychiatric illness (type and year): _____

How healthy were you as a child? _____

How supportive were your parents and environment? _____

Toxic Exposures

Do you smoke / use tobacco? No Yes If yes, please give details _____

How much alcohol do you use, and what kinds? _____

Do you have: Amalgam (mercury-silver) fillings Root canals Dental infections

Do you feel that you use more sugar or caffeine than is good for you? _____

Do you use artificial sweeteners? If yes, please give details _____

What toxic chemicals are you exposed to at work or at home? (exhaust fumes, new carpets ...) _____

What type of water do you drink? Municipal tap water Private well water Filtered / RO

Life Habits & Situation

Please check any or all of the following that apply to how you eat:

Eat too little Eat too much Get enough protein Get enough healthy fats

Eat processed foods Eat unprocessed foods Eat balanced meals Eat organic

Lots of nonstarchy vegetables Get enough carbohydrate Get too much carbohydrate

Go for a long time between meals Drink plenty of water Don't drink much water

How much do you exercise? _____

How well do you sleep? _____

Please describe your work situation _____

Please describe your home situation _____

How stressful is your life right now? _____

What do you do to relax and have fun? _____

Comments: _____

Family History

Do you have a family history of breast cancer? No Yes

Do you have a family history of osteoporosis? No Yes

If yes to either, please give details _____

Current Symptoms

Please check the box next to each symptom or sign that you currently have, or have experienced in the past 6 months. On the line next to each that you checked, please note which conditions are most severe or of most concern to you.

Also, please note if any symptoms are cyclic (vary with your menstrual cycle).

Energy, Fluids & Metabolism

- Fatigue _____
- Feeling stressed _____
- Feeling burned out _____
- Decrease in stamina _____
- Decrease in ability to exercise _____
- Difficulty keeping weight on _____
- Unstable blood sugar _____
- Craving for sugar _____
- Craving for salt _____
- Water retention _____
- Unexplained or rapid weight gain _____
- Inability to lose weight _____
- Elevated cholesterol _____
- Elevated triglycerides _____
- Night sweats _____
- Hot flashes _____
- Always feeling cold _____
- Cold hands and feet _____

Skin / Hair

- Acne or oily skin _____
- Increase in face or body hair _____
- Excessive sweating _____
- Decreased sweating _____
- Thinning or sagging skin _____
- Excessively dry skin _____
- Loss of head hair, pubic hair or eyebrows _____

Eyes / Ears / Nose / Throat

- Puffiness around or under eyes _____
- Light sensitivity _____
- Hoarseness _____
- Excessive salivation _____

Breasts

- Breast tenderness or pain

Cardiovascular

- Palpitations (irregular heartbeat)
- Low blood pressure
- Dizziness / lightheadedness
- High blood pressure

Gastrointestinal

- Heartburn or acid reflux
- Constipation
- Gallbladder problems

Genitourinary

- Heavy menstrual bleeding
- Bleeding between periods
- Infrequent periods
- Pain during periods
- Mid-cycle pain
- Post-menopausal bleeding
- Vaginal dryness
- Painful intercourse
- Decreased sex drive
- Increased urinary urge
- Urinary incontinence
- Pain while urinating
- Bladder infections
- Vaginal yeast infections

Musculoskeletal

- Decreased muscle mass
- Decreased strength
- Decreased bone density
- Aches and pains

Immune System

- Allergies including food allergies
- Chemical sensitivities
- Frequent respiratory infections

Nervous System

- Insomnia or disturbed sleep
- Headaches

- Mood swings _____
- Weepiness _____
- Irritability or anger _____
- Indecisiveness _____
- Decreased mental focus _____
- Foggy thinking _____
- Memory lapses _____
- Lethargic depression / apathy _____
- Nervousness / anxiety _____
- Anxious depression _____
- Panic attacks _____
- Numbness in hands or feet _____
- Loss of balance or coordination _____

Vital Signs

Height _____ Current weight _____ What do you feel is your ideal weight? _____
 Blood Pressure (typical reading) _____ Typical heart rate _____ Typical body temp _____

Past Lab Tests

Please indicate the most recent date and result (you may not have had all of these tests):

- Cholesterol Date _____ Result _____
- Triglycerides Date _____ Result _____
- Insulin Date _____ Result _____
- Fasting Glucose Date _____ Result _____
- Thyroid screen (TSH) Date _____ Result _____
- Female hormones Date _____ Result _____
- Adrenals (DHEA, cortisol) Date _____ Result _____
- Mammogram/Thermogram Date _____ Result _____
- Bone density Date _____ Result _____

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