




## Review of Systems

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST, AND INDICATE HOW OFTEN.

1. GENERAL ISSUES	CURRENTLY	PAST	NOTES
Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	
Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	
2. EYES			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
Vision changes	<input type="checkbox"/>	<input type="checkbox"/>	
Eye disease or injury	<input type="checkbox"/>	<input type="checkbox"/>	
Wear glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	
Eye surgery for correction	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	
3. EARS, NOSE AND THROAT			
Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing loss/deafness	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble breathing through nose	<input type="checkbox"/>	<input type="checkbox"/>	
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	
4. CARDIOVASCULAR (ALSO, <b>PLEASE COMPLETE HEART HISTORY APPENDIX</b> )			
Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult breathing on exertion	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling of ankles or legs	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations of heart	<input type="checkbox"/>	<input type="checkbox"/>	
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Rapid or irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	
Are you supposed to take antibiotics before dental work?			<input type="checkbox"/> <input type="checkbox"/>
5. RESPIRATORY			
Wheezing or asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Spitting up or coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	
Cough up phlegm	<input type="checkbox"/>	<input type="checkbox"/>	
TB or positive TB test	<input type="checkbox"/>	<input type="checkbox"/>	last PPD _____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	
6. BONES AND JOINTS			
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis/joint pains or swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Morning stiffness lasting >1 hr	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling in hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble walking	<input type="checkbox"/>	<input type="checkbox"/>	
Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	

PLEASE CHECK (X) IF ANY OF THE FOLLOWING APPLY TO YOU NOW, IN THE PAST, AND INDICATE HOW OFTEN.

	CURRENTLY	PAST	NOTES
<b>7. DIGESTIVE SYSTEM</b>			
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody or black bowel movement	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Ever vomit blood	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids/piles	<input type="checkbox"/>	<input type="checkbox"/>	
Use laxatives	<input type="checkbox"/>	<input type="checkbox"/>	
Problems with fatty or greasy foods	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
Other Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	
Crampy abdominal pains	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
Heartburn or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	
Use antacids	<input type="checkbox"/>	<input type="checkbox"/>	
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
Intolerance of spicy food, caffeine or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	
<b>8. BLADDER/KIDNEYS</b>			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	
Urgent need to urinate	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent need to urinate	<input type="checkbox"/>	<input type="checkbox"/>	
Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of urine with cough or sneeze	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent bladder infections	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty starting urinating	<input type="checkbox"/>	<input type="checkbox"/>	
Get up during the night to urinate	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9. SKIN</b>			
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	
Skin masses	<input type="checkbox"/>	<input type="checkbox"/>	
Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	
Skin ulcers	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10. NERVOUS SYSTEM</b>			
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Numbness/paralysis	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11. OTHER</b>			
Abnormal thirst	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
Bruising	<input type="checkbox"/>	<input type="checkbox"/>	
Cuts do not stop bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Enlarged lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle cell or inherited blood problem	<input type="checkbox"/>	<input type="checkbox"/>	
<b>12. ALLERGIC/IMMUNOLOGIC</b>			
Any autoimmune diseases	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Other Immune Deficiency Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	

Do you have any disabilities?  No  Yes (Describe):


How would you rate your health as a child:  Good  Fair  Poor

List any serious childhood illnesses:


Are you aware of any injuries at birth (physical or emotional, family issues, etc...)


Where you born vaginally  or by cesarean section?

Are you aware of medical problems your mother experienced while pregnant with you?  No  Yes (Describe):


Are you aware of any emotional or stressful circumstances your mother experienced while pregnant with you?  No  Yes (Describe):


**Please complete the Appendices on LABORATORY TESTING and IMMUNIZATION HISTORY**

**Have you ever had surgery or had any injuries? (Include major dental work)**

Surgery or injury	How treated	When

**Do you have any allergies to medications, foods, pollens, etc.?**

Allergen/Triggers (medication, food, etc.)	Reaction

**Have you been exposed to anything in the environment that you think may have affected your health? (Include work space, home space issues such as air circulation, dust, mold, fumes, etc....)**


**List any prescription medications you are taking:**

Medication	Reason for taking	Dose/Times per day	Year started	Side Effects

- Are you having trouble being able to pay for your medications?  No  Yes  
 Do you cut back on the use of any medications because of costs or side effects?  No  Yes  
 Are their medications that you have chosen not to take because of the costs or side effects?  No  Yes

**Please describe side effects or cost concerns listed above:**


**List any over the counter medications you are taking:**

Medication	Reason for taking	Dose/Times per day	Year started	Side Effects

**List any herbs, supplements or vitamins you are taking: (Give Brand)**

Supplement	Reason for taking	Dose/Times per day	Year started	Side Effects

**History with Complementary or Alternative Therapies**

Type	Never Tried	Use Currently	Not for me	Interested In
Massage				
Acupuncture				
Chinese herbs				
Other herbs				
Homeopathy				
Chiropractic				
Osteopathy				
Nutrition				
Mind-Body (Hypnotherapy, Biofeedback, etc...)				
Reiki				
Other energy therapies (healing touch, polarity, etc...)				
Others:				





## Family History

Problem	Have you had in Past or Now?	Family member has had? (list who)	Type of problem	How treated
Heart disease				
High blood pressure				
Stroke				
Cancer				
Diabetes				
High cholesterol				
Depression, anxiety or other mental health problems				
Colon polyps or colon cancer				
Other problems				

Were you adopted?  No     Yes (Do you have any medical knowledge about your biological family?)

### Are there any medical conditions that run in your family?

Problem	Family member(s)

Health Status of Immediate Family:

Family Member	Age	Health Problem
Parents:		
Siblings:		
Children:		
Spouse/Significant Other:		

Optional: Please Draw your Family Tree (see Appendix)

## Preventive Health

**Do you participate in any physical activity or exercise?** Example: walking, going to the gym, cleaning houses, sports, etc.

Activity	Amount of time/day or week

Do you do any type of flexibility exercises such as Tai Chi, Yoga or stretching?     No     Yes

Do you do any type of resistance or weight training?     No     Yes

Are you interested in being more physically active?     No     Yes

What types of physical activity would you like to be involved in? \_\_\_\_\_  
 \_\_\_\_\_

What would you like to achieve from being physically active? \_\_\_\_\_  
 \_\_\_\_\_

What keeps you from being physically active? \_\_\_\_\_  
 \_\_\_\_\_

Are there specific things that you do in order to maintain your health?     No     Yes    What are they?  
 \_\_\_\_\_  
 \_\_\_\_\_

Are there specific ways that you monitor your body or your health?     No     Yes    What are they?  
 \_\_\_\_\_  
 \_\_\_\_\_

If you feel as if you are “coming down” with something, are there specific things that you do or don’t do to take care of yourself?     No     Yes    What are they?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How much direct sunshine do you receive during an average day? \_\_\_\_\_ minutes

Do you wear sunscreen:     Daily     When in sun     Just on face     Never

Do you wear a seat belt when you drive?     Sometimes     Always     Never  
 When you are a passenger?     Sometimes     Always     Never

If you have small children, do they ride in a car seat?     No     Yes  
 Do they ever ride in the front seat of the car?     No     Yes

How many times a day do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_  
 When was your last dental exam? \_\_\_\_\_

Do you have any difficulty chewing or swallowing your food?     No     Yes

Are there any guns or other weapons in your house, car or storage area?  No  Yes  
Are the guns kept separately from the ammo?  No  Yes  
Do they all have gun locks?  No  Yes

Does each floor of the house have a smoke detector?  No  Yes  
If it has a battery do you check it twice a year? (e.g. clock changes in fall and spring)  No  Yes

Is your water heater and furnace clear of flammable materials and debris?  No  Yes  
Do you have a carbon monoxide detector?  No  Yes Radon detector?  No  Yes  
Do you have a fire extinguisher in the kitchen?  No  Yes Do you check it yearly?  No  Yes

Have you ever taken a course in: CPR?  No  Yes First Aid?  No  Yes Fire safety?  No  Yes  
Disaster/Earthquake response?  No  Yes

Do you feel safe in your neighborhood?  No  Yes  
Have you ever taken a self defense class?  No  Yes

Name three things you know you should be doing for your health but are not currently doing?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Physical Activity

University of Arizona School of Medicine Program in Integrative Medicine, Associate Fellowship

### Barriers to being active quiz

**Directions:** Listed below are reasons that people give to describe why they do not get as much physical activity as they think they should. Please read each statement and indicate by circling a number how likely you are to say each of the following statements:

How likely are you to say:	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely
1. My day is so busy now, I just don't think I can make the time to include physical activity in my regular schedule.	3	2	1	0
2. None of my family members or friends like to do anything active, so I don't have a chance to exercise.	3	2	1	0
3. I'm just too tired after work to get any exercise.	3	2	1	0
4. I've been thinking about getting more exercise, but I just can't seem to get started.	3	2	1	0
5. I'm getting older so exercise can be risky.	3	2	1	0
6. I don't get enough exercise because I have never learned the skills for any sport.	3	2	1	0
7. I don't have access to jogging trails, swimming pools, bike paths, etc.	3	2	1	0
8. Physical activity takes too much time away from other commitments - like work, family, etc.	3	2	1	0
9. I'm embarrassed about how I will look when I exercise with others.	3	2	1	0
10. I don't get enough sleep as it is. I just couldn't get up early or stay up late to get some exercise.	3	2	1	0
11. It's easier for me to find excuses not to exercise than to go out and do something.	3	2	1	0
12. I know of too many people who have hurt themselves by overdoing it with exercise.	3	2	1	0
13. I really can't see learning a new sport at my age.	3	2	1	0

14. It's just too expensive. You have to take a class or join a club or buy the right equipment.	3	2	1	0
15. My free times during the day are too short to include exercise.	3	2	1	0
16. My usual social activities with family or friends do not include physical activity.	3	2	1	0
17. I'm too tired during the week and I need the weekend to catch up on my rest.	3	2	1	0
18. I want to get more exercise, but I just can't seem to make myself stick to anything.	3	2	1	0
19. I'm afraid I might injure myself or have a heart attack.	3	2	1	0
20. I'm not good enough at any physical activity to make it fun.	3	2	1	0
21. If we had exercise facilities and showers at work, then I would be more likely to exercise.	3	2	1	0

## Nutrition History

Are you currently on a special diet?  No  Yes If yes, describe: \_\_\_\_\_

Have you ever felt out of control of your eating habits?  No  Yes

Have you had struggles with frequent vomiting, making yourself vomit or eating so little over periods of time that you or others were worried?  No  Yes

Your current Weight \_\_\_\_\_ Height \_\_\_\_\_ BMI \_\_\_\_\_

Please calculate your Body Mass Index (**BMI**):  $\frac{\text{Weight (pounds)}}{\text{Height (inches)}^2} \times 700 = \text{BMI}$  \_\_\_\_\_

**Example:**  $\frac{\text{Weight } 125\text{lbs} \times 700}{\text{Height } 64'' \times 64''} = 87500 = \text{BMI of } 21$

How much did you weigh 5 years ago? Weight? \_\_\_\_\_ lbs.

How much did you weigh when you were 21? Weight? \_\_\_\_\_ lbs.

In the last year, have you experienced significant weight loss or gain?  No  Yes

If yes, describe: \_\_\_\_\_

List all the foods you have eaten in the last 24 hours including snacks and beverages:

Breakfast	Foods/Beverage	Amount	How prepared	Where eaten	At what time?
Lunch	Foods/Beverage	Amount	How prepared	Where eaten	At what time?
Dinner	Foods/Beverage	Amount	How prepared	Where eaten	At what time?
Snacks	Foods/Beverage	Amount	How prepared	Where eaten	At what time?

Is this a typical day for you?  No  Yes If not, how is it different? \_\_\_\_\_

Who usually prepares your meals? \_\_\_\_\_

Do you usually eat alone or with someone? \_\_\_\_\_

What percentage of meat, eggs, poultry, fruits and vegetables you eat are organic? \_\_\_\_\_%

**Are there any types of foods that you crave?**

Food	Why?

**Are there any types of foods that you do not eat?**

Food	Why?

**How many servings of fruit do you eat/drink each day? \_\_\_\_\_**

Serving= 1 small piece of fruit, ½ cup of juice, ½ cup canned or chopped fruit, ¼ dried fruit

**How many servings of vegetables do you eat/drink each day? \_\_\_\_\_**

Serving= ½ cup raw or cooked, 1 cup fresh leafy vegetables, ¼ cup dried or 1 small piece

How many times do you eat out each week? \_\_\_\_\_

How many times do you eat "fast food" each week? \_\_\_\_\_

How many servings of red meat (beef, lamb, pork, etc.) do you eat each week? \_\_\_\_\_

How many servings of poultry (chicken, turkey, duck, etc.) do you eat each week? \_\_\_\_\_

How many servings of fish do you eat each week? \_\_\_\_\_

How many servings of whole grains such as wheat berries, barley, oats, etc. do you eat each week? \_\_\_\_\_

How many servings of beans (black, pinto, lentils, etc.) do you eat each week? \_\_\_\_\_

How many servings of soy (tofu, soy milk, tempeh, etc.) do you eat each week? \_\_\_\_\_

How many servings of dairy products (milk, ice cream, yogurt, etc.) do you eat each week? \_\_\_\_\_

What type of oil/spreads (corn, olive, canola, butter, margarine, flax, etc.) do you usually cook with or have added to your food? \_\_\_\_\_

How many glasses of the following drinks do you consume each day?

- |           |                       |               |                       |
|-----------|-----------------------|---------------|-----------------------|
| water     | _____glasses/cups/day | herb tea      | _____glasses/cups/day |
| coffee    | _____glasses/cups/day | fruit juice   | _____glasses/cups/day |
| decaf     | _____glasses/cups/day | beer          | _____glasses/cups/day |
| soda      | _____glasses/cups/day | wine          | _____glasses/cups/day |
| diet soda | _____glasses/cups/day | other alcohol | _____glasses/cups/day |
| tea       | _____glasses/cups/day | other         | _____glasses/cups/day |
| green tea | _____glasses/cups/day |               |                       |

How many sweets or desserts **or snacks** do you eat each day? \_\_\_\_\_ What types and when: \_\_\_\_\_

## NUTRITION QUESTIONNAIRE

Please check which column most accurately describes how often you consume a serving of the following foods/beverages:

Servings of:	None	1x/week	3-5x/week	1x/day	2-3x/day	3-5x/day	5-9x/day
6 oz water							
½ cup fruit or vegetable							
whole grain cereal, bread, brown rice, wheatberry, quinoa, oats							
beans/legumes							
green/black/white tea							
olive oil, canola oil, olives, avocados							
small handful of nuts							
4 oz soy protein (tofu, tempeh, soy milk)							
clove of garlic							
cold water fish (salmon, tuna, mackerel)							
flaxseed							
small handful of seeds							
dark chocolate							
poultry							
dairy products							
white potatoes, rice or flour, bread							
caffeinated coffee, cola							
diet drinks							
butter							
vegetable oil							
margarine							
something from a box with a long shelf life							
red meat							
alcohol							
fried foods							
sweets/candy							
fast food							

## Social History

Do you live with anyone? If so, who? Please include pets.

Name	Age	Relationship

Marital/Partner Status:

Past (e.g. married twice) \_\_\_\_\_

Current (Single, Married, Partnered, divorced.....) \_\_\_\_\_

With whom do you have the most significant relationships? \_\_\_\_\_

Closest? \_\_\_\_\_

Most problematic? \_\_\_\_\_

With whom do you share your feelings? \_\_\_\_\_

Who would you call for a favor? \_\_\_\_\_

Do you belong to a group or community? \_\_\_\_\_

Have you ever been in a support program for a medical condition?  No  Yes Describe: \_\_\_\_\_

Do you have enough money to meet your needs?  No  Yes

What do you do with your time? Example: work, school, care for home or children, etc.


What have you done in the past?


How much TV do you watch each day? \_\_\_\_\_ hours

Have you served in the armed forces?  No  Yes If yes, give details: \_\_\_\_\_


Where were you born? \_\_\_\_\_

Where have you lived? \_\_\_\_\_  
\_\_\_\_\_

Where have you traveled? \_\_\_\_\_  
\_\_\_\_\_

Where would you like to go? \_\_\_\_\_

What interests/hobbies do you have? \_\_\_\_\_

What magazines do you read regularly? \_\_\_\_\_

Please list the last 3 books that you have read:


Do you do any volunteer work?  No  Yes If yes, describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Sexual Health

Do you have sex with:  Men  Women  Transgender  No one

Age of first intercourse: \_\_\_\_\_ Number of partners in the past year: \_\_\_\_\_

What type of sex do you have:  Vaginal  Anal  Oral (Check all that apply)

Have you ever had sex with someone who...

has HIV?  No  Yes uses needles?  No  Yes

is a bisexual?  No  Yes

Which safer sex protection do you use? \_\_\_\_\_

Do you use any form of birth control?  No  Yes  N/A If yes, what \_\_\_\_\_

Are you happy with this method?  No  Yes

Have you ever used:

Condoms  The pill  Depo shot  Diaphragm  Cervical cap  Norplant  Spermicides  Withdrawal

Female condom  IUD  Natural family planning

Have you ever had:  Chlamydia  Gonorrhea  Genital Warts/HPV  Herpes  Syphilis  HIV

Are you currently sexually involved in any way?  No  Yes If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Are you happy with your sex life?  No  Yes Comments: \_\_\_\_\_  
\_\_\_\_\_

If there was one thing you could change about your sex life, what would it be? \_\_\_\_\_  
\_\_\_\_\_

Have you ever used any sexual enhancement drugs (Viagra, Levitra, Cialis, etc.) or herbals?  No  Yes  
Describe: \_\_\_\_\_

## Women's Health History

Age periods began: \_\_\_\_\_ Age periods stopped: \_\_\_\_\_

How often do you (or did you) get your period? \_\_\_\_\_ days. Is (was) it regular?  No  Yes

How long does (did) it last? \_\_\_\_\_ days

Do you/Did you bleed between periods?  No  Yes

Do you/Did you have bad cramps?  No  Yes

Do you/Did you have premenstrual symptoms?  No  Yes Describe: \_\_\_\_\_

Do you have menopausal symptoms?  No  Yes Describe: \_\_\_\_\_

Do you have pain or bleeding with sex?  No  Yes

Any history of fibroids, endometriosis, ovarian cysts or other reproductive health problems?  No  Yes

Describe: \_\_\_\_\_

Have you ever had an abnormal Pap smear?  No  Yes When? \_\_\_\_\_ Results \_\_\_\_\_

Did you have: (check all that apply) – Colposcopy \_\_\_\_\_ Treatment \_\_\_\_\_

Repeat Pap smears normal \_\_\_\_\_

Have you ever had an abnormal mammogram?  No  Yes When \_\_\_\_\_ Results \_\_\_\_\_

Where performed \_\_\_\_\_ Further testing \_\_\_\_\_

Do you have breast pain, discharge, skin changes or any other problems?  No  Yes

Describe: \_\_\_\_\_

Have you had any breast surgeries?  No  Yes Describe: \_\_\_\_\_

Have you ever had:  Pelvic inflammatory disease (PID)  Frequent Yeast Infections  Frequent Bacterial Vaginal (BV) Infections

Number of .....pregnancies: \_\_\_\_\_

births: \_\_\_\_\_

miscarriages: \_\_\_\_\_

abortions: \_\_\_\_\_

living children: \_\_\_\_\_

Any problems with any pregnancies?  No  Yes If yes, what? \_\_\_\_\_

Have you had problems getting pregnant?  No  Yes If yes, describe: \_\_\_\_\_

Have you ever had an upsetting medical or pelvic exam?  No  Yes If yes, describe: \_\_\_\_\_

Family history of breast or ovarian cancer?  No  Yes Who? \_\_\_\_\_

Do you examine your own breasts?  Sometimes  Never  Monthly

When was the last time your health care provider examined your breasts? \_\_\_\_\_

Family history of osteoporosis (weak or broken bones)?  No  Yes If yes, describe: \_\_\_\_\_

Who? \_\_\_\_\_

Have you ever had bone density testing?  No  Yes If yes, When \_\_\_\_\_ Where \_\_\_\_\_

## Menopause Rating Scale\* (MRS)

	Which of the following symptoms apply to you at this time?	None	Mild	Moderate	Severe	Very Severe
	Score	0	1	2	3	4
1	Hot flushes, sweating (episodes of sweating)					
2	Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)					
3	Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early)					
4	Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)					
5	Irritability (feeling nervous, inner tension, feeling aggressive)					
6	Anxiety (feeling restless, feeling panicky)					
7	Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)					
8	Sexual problems (change in sexual desire, in activity and satisfaction)					
9	Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)					
10	Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)					
11	Joint and muscular discomfort (pain in the joints, rheumatoid complaints)					

Scoring has not been standardized, but a total score of at least 16 is required for diagnosis of “menopause syndrome”

\*(MRS) has been released by the author for distribution

## Abuse

Have you ever been abused emotionally (treated in a mean, nasty or cruel manner) by your partner or someone important to you?  No  Yes If yes, by whom? \_\_\_\_\_

Within the last year, have you been hit, slapped kicked or otherwise physically hurt by someone?

No  Yes If yes, by whom? \_\_\_\_\_

Within the last year, has anyone forced you to have sexual activities?  No  Yes If yes, whom?

\_\_\_\_\_  
Are you afraid of your partner or anyone listed above?  No  Yes If yes, of whom?

\_\_\_\_\_  
Would you like to discuss these things today?  No  Yes

Would you like information on domestic violence or sexual assault resources in your area?  No  Yes

## Emotional/Spiritual Health

What are the major stressors in your life? \_\_\_\_\_  
 \_\_\_\_\_

How would you rate your stress level in the past month?

Circle the appropriate spot on the line below.

**1      2      3      4      5      6      7      8      9      10**  
 Completely relaxed Extremely stressed

What do you do to relax? \_\_\_\_\_

Where is your favorite place to relax? \_\_\_\_\_

What is your favorite season, and why? \_\_\_\_\_

How would you rate your emotional state in the past month?

Circle the appropriate spot on the line below.

**1      2      3      4      5      6      7      8      9      10**  
 Very Sad Very Happy

Have you ever been to a support program or therapist for emotional issues (depression, anxiety, anger, panic attacks, etc)?  No  Yes

Do you have any phobias?  No  Yes If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please check the appropriate column:**

	Over the past two weeks, how often have you:	None or little of the time	Some of the time	Most of the time	All of the time
1	been feeling low in energy, slowed down?				
2	been blaming yourself for things?				
3	had poor appetite?				
4	had difficulty falling asleep, staying asleep?				
5	been feeling hopeless about the future?				
6	been feeling blue?				
7	been feeling no interest in things?				
8	had feelings of worthlessness?				
9	thought about or wanted to commit suicide?				
10	had difficulty concentrating or making decisions?				

Would you consider yourself to be more of an optimist or a pessimist? Place an X in the appropriate spot on the line below.

\_\_\_\_\_  
**0** **10**  
 Pessimist Optimist

List any important/stressful anniversaries. (e.g., births, deaths, accidents, events, losses, illnesses, etc.)

---

Are there any other significant traumas (emotional, physical, world events, etc.) that have affected you?

Please explain: \_\_\_\_\_

---

Have you ever been evaluated for post traumatic stress disorder or depression?  No  Yes

If not, do you have questions about it?  No  Yes

What are your sources of hope or strength when things are difficult? \_\_\_\_\_

---

Are you part of an organized religion?  No  Yes Describe: \_\_\_\_\_

---

Is religion or spirituality important to you?  No  Yes If yes, in what way? \_\_\_\_\_

---

Do you have a personal spiritual practice?  No  Yes Describe: \_\_\_\_\_

---

Do your religious or spiritual beliefs influence the way you look at your medical problems and the way you think about your health? Please explain: \_\_\_\_\_

---

Do your current challenges influence your faith? \_\_\_\_\_

---

### Relaxation Methods

Technique	Never Tried	Use Currently	Not for me	Interested In
Progressive muscle relaxation				
Meditation				
Visualization/Guided imagery				
Hypnosis				
Breathing exercises				
Yoga				
Tai Chi/Chi Gong				
Massage/body work				
Biofeedback				
Other:				

Now that you have completed this extensive evaluation please summarize what you do for you own health/healing:


Is there anything else about your health you think we should know?


Please restate your goals:


Lastly, how do you learn best?

- Individually
- Hearing information
- In a Group
- Reading
- Applying
- Experience



# Appendix

## Heart History

Events/Conditions	You? What Age(s)?	Family Member? Who? What Age(s)?
1. Heart Attack / Cardiac Arrest	_____	_____
2. Heart Rhythm Problems	_____	_____
3. Heart Surgery / Bypass	_____	_____
4. Heart Pacemaker / Defibrillator	_____	_____
5. Heart Valve Repair/Replacement	_____	_____
6. Heart Infections / Injury	_____	_____
7. Congestive Heart Failure	_____	_____
8. High Blood Pressure	_____	_____
9. Stroke, Bleed/Clot in the Brain	_____	_____
10. (Carotid) Neck Artery Surgery	_____	_____
11. Leg Cramps with Activity	_____	_____
12. Childhood Heart Problems	_____	_____
13. Rheumatic Fever	_____	_____
14. High Cholesterol	_____	_____

# Appendix

## Laboratory Testing Results

Laboratory Testing if known. (It would be helpful if you could transfer specific tests results to this form.)  
In addition you can affix any additional or more comprehensive reports that may be available at this time.

	Result	Date
Total Cholesterol	_____	_____
HDL	_____	_____
LDL	_____	_____
Triglycerides	_____	_____
Apolipoprotein A	_____	_____
Apolipoprotein B	_____	_____
Lipoprotein (a)	_____	_____
Homocysteine	_____	_____
High Sensitivity (Cardiac) C-Reactive Protein	_____	_____
Fasting Glucose	_____	_____
Hemoglobin A1C	_____	_____
Hemoglobin	_____	_____
Hematocrit	_____	_____
Platelet Count	_____	_____
White Blood Cells (total)	_____	_____
Thyroid Stimulating Hormone (TSH)	_____	_____
Thyroxine (T4)	_____	_____

Last Colonoscopy & Results: \_\_\_\_\_

Cardiac Stress Test Results: \_\_\_\_\_

What was your highest Blood pressure ever recorded? \_\_\_\_\_

What is your average blood pressure range? \_\_\_\_\_

Blood Type: \_\_\_\_\_

When was your last comprehensive physical examination? \_\_\_\_\_

By whom? \_\_\_\_\_

## Appendix

### Immunization History

Immunization	Age/Date (s)	Reaction, if any
Cholera		
Diphtheria		
Hemophilus Influenza b (HIB)		
Hepatitis A		
Hepatitis B		
Influenza (flu)		
Japanese Encephalitis		
Menigococcus		
Pertussis		
Pneumococcus		
Polio (indicate oral or injected)		
Smallpox		
Tetanus		
Typhoid		
Yellow Fever		
Other		

# Appendix

## Draw your medical family tree

After you collect your family medical history, you may want to put it into an easy-to-read diagram called a medical family tree. There's no right or wrong way to map your family's medical history — just be sure it's easy to read and interpret. Here are some tips.

### Get organized

Start by organizing your relatives and separating them into generations. The number of generations you include will depend on how much information you collect.

If your information starts with your grandparents, put them at the top of your diagram. The next generation of your family — your parents, aunts and uncles — is drawn below your grandparents. You, your sisters and brothers, and your cousins are the next generation and go on the next line. Your children, nieces and nephews are the next generation, and their children are on the next level.

### Pick your symbols

You can use whatever symbols are easiest for you to understand and remember. Doctors tend to use a set of common symbols when assembling medical family trees. These symbols include:

**Squares** to distinguish male family members

**Circles** for female family members

**A line or X** through a square or circle to signify a deceased family member

**Brackets** around a square or circle to indicate an adopted family member

Pick symbols you'll use consistently throughout your medical family tree. It might help to make a legend in a corner of your diagram to help others interpret the shapes you choose. Draw lines between family members to show how they're related.

### Fill in the details

Next, put the health information into your diagram. Write each relative's diseases and conditions below his or her symbol. If you're feeling creative, you might try assigning a color or symbol to each condition and then color or label each relative with that information. There's no right or wrong way to organize the information. Pick whatever method is easiest for you to interpret. This will make it easier for you to pick out the conditions that are being passed through your family.

### Software available

Computer software is available to help you build your medical family tree. Such software simplifies updating or revising your information. But it won't gather your family's health history for you. Genealogy Web sites have information on software you can purchase, or you can enter a phrase such as "family tree software" into a search engine to find information on the Internet.

### Problems with medical family trees

A medical family tree won't work for everyone looking for answers about hereditary health concerns. If you have a small family with few brothers, sisters and cousins, it will be difficult to identify health patterns in your family. And medical family trees only work for blood relatives. If you're adopted and don't know your biological parents, your adopted family's tree won't tell you about your risk of inherited diseases.

You might also find that some relatives prefer to keep some health information private. Relatives may not want to talk about an uncle's alcoholism, a niece's treatment for mental illness, a nephew's dyslexia or a grandmother's Alzheimer's disease. Solving this problem calls for tact and compassion. The following strategies can help:

**Explain your purpose.** Emphasize that your purpose is to create a diagram that will help determine whether you and your relatives have a family history of certain diseases or health conditions. Offer to make the medical family tree available to other family members so that they can share the information with their doctors.

**Provide several ways to answer questions.** Some people may be more willing to share health information in a face-to-face meeting. Others may prefer answering your questions by mail or e-mail.

**Word questions carefully.** Don't start with personal questions. Begin your interview by asking questions about the whole family and then let your relative volunteer her or his personal health information.

**Be a good listener.** As your relatives talk about their health problems, let them speak without interruption. Listen without judgment or comment.

**Respect privacy.** As you collect information about your relatives, respect their right to confidentiality. Some people may not want to share any health information with you. Or they may not want this information revealed to anyone other than you.

### **See your medical provider**

Take your medical family tree with you to your next appointment. Your provider can help you analyze disease patterns throughout your family and can talk with you about your risk of developing certain diseases. If you're curious about genetic testing, your provider can discuss this with you and help you determine whether genetic testing is right for you.

<http://www.cnn.com/HEALTH/library/HQ/01707.html>

## Resources

### Risk Calculators on the Internet

The following risk calculators, all available on the Internet, can help you and your patients assess their risk for a variety of clinical conditions and then use the information to formulate a shared care plan.

Breast cancer

<http://bcra.nci.nih.gov/brc/q1.htm>

<http://www.halls.md/breast/risk.htm>

Cancer (general)

<http://www.yourcancerrisk.harvard.edu/>

Coronary heart disease

<http://hin.nhlbi.nih.gov/atp/iii/calculator.asp>

<http://www.intmed.mcw.edu/clinicalc/heartrisk.html>

<http://www.med-decisions.com/cvtool/index.html> (also offers a version for the handheld computer)

Diabetes-related

<http://www.dtu.ox.ac.uk/riskengine/download.html>

<http://www.healthandage.com/tools/diab/indexdiab.jsp>

<http://www.footandankle.com/DMfoot/start.html>

Osteoporosis

[http://www.indiadiets.com/calculators/risk\\_osteoporosis.htm](http://www.indiadiets.com/calculators/risk_osteoporosis.htm)

Prostate cancer

<http://www.prostatecalculator.org/introduction.html>

Smoking-related

[http://www.medindia.net/patients/calculators/ciger\\_smoke.asp](http://www.medindia.net/patients/calculators/ciger_smoke.asp)

Strep throat

<http://www.aafp.org/fpm/20030900/sorethroatencounterform.pdf>

### Guidelines:

AHA Guidelines CV Health - Primary Prevention

<http://circ.ahajournals.org/cgi/content/full/106/3/388>

AHA Secondary Prevention

<http://circ.ahajournals.org/cgi/content/full/104/13/1577>

AHA Stroke

<http://stroke.ahajournals.org/cgi/content/full/30/11/2502>

AHA CVD and Women

<http://circ.ahajournals.org/cgi/content/full/99/18/2480>

<http://www.americanheart.org/presenter.ihtml?identifier=3018997>

<http://www.americanheart.org/presenter.ihtml?identifier=3018778>

(AHA on Diet)

<http://circ.ahajournals.org/cgi/content/full/102/18/2284>

### Other Resources:

Sexual Counseling:

<http://www.medscape.com/viewarticle/420226?src=search>

Violence screening:

<http://endabuse.org/programs/healthcare/files/Consensus.pdf>

See also article on improving screening for women with violence:

<http://www.medscape.com/viewprogram/2777>

Adult immunizations:

<http://www.cdc.gov/nip/recs/adult-schedule.pdf>

Substance abuse screening:

<http://www.gpnotebook.co.uk/simplepage.cfm?ID=-1389035520>

Other substance abuse screening tools by age, culture, etc.:

[http://www.bhworld.com/library3.cfm?level\\_id=2&category\\_id=209&layer=1&cat1=209&lay1=1](http://www.bhworld.com/library3.cfm?level_id=2&category_id=209&layer=1&cat1=209&lay1=1)

Exercise Assessment tools:

[http://www.ipaq.ki.se/IPAQ.asp?mnu\\_sel=DDE&pg\\_sel=DDE](http://www.ipaq.ki.se/IPAQ.asp?mnu_sel=DDE&pg_sel=DDE)

<http://www.uri.edu/research/cprc/Measures/Exercise02.htm>

### Rheumatoid arthritis:

NIH Patient Handout on RA – [www.niams.nih.gov/hi/topics/arthritis/rahandout](http://www.niams.nih.gov/hi/topics/arthritis/rahandout)

American College of Rheumatology - [www.rheumatology.org](http://www.rheumatology.org)

Arthritis Foundation - [www.arthritis.org](http://www.arthritis.org)