

HEALTH HISTORY QUESTIONNAIRE - FEMALE

Please **SCAN** or **FAX** completed form to Dr. Mead's office at: **415 500 8311**

Date: _____

(All information is held absolutely CONFIDENTIAL)

Name: _____

Birth Date: _____

Age: _____

Address: _____

City: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Email Address: _____

Occupation: _____

Emergency Contact Information:

Name: _____

Relationship to you: _____

Contact Numbers: _____

Names of other Healthcare Providers:

Are you currently under the care of another Physician? _____

Are you currently taking any medications? Please list:

Are you currently on any supplements or remedies? Please list:

How did you hear about our clinic?

What are your main concerns today and when did they begin?

Have they been diagnosed? If so, when?

Have there been any improvements made? If so, please list.

Past/Recent Surgeries?

Past/Recent Trauma (Physical and emotional)?

Do you have any allergies?

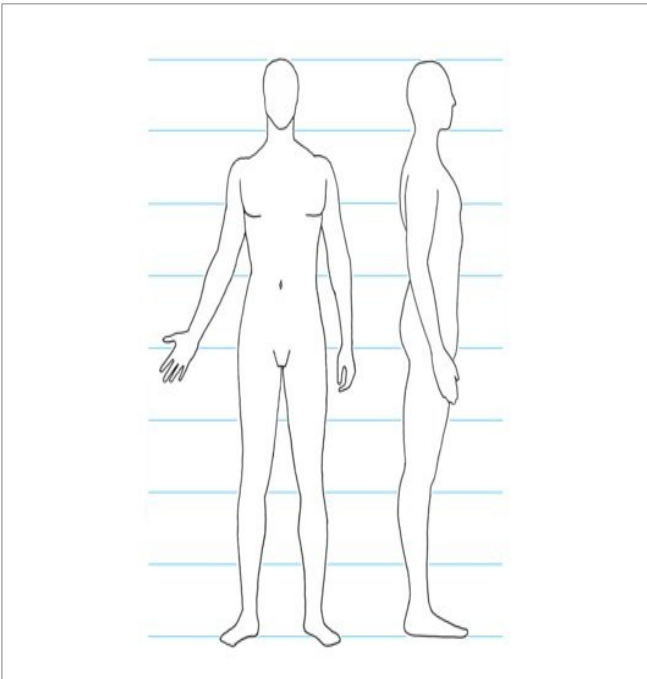
Please indicate any other problems you would like to discuss:

Exam and Imaging History

Indicate date, doctor's name, or place of most recent tests

Full Physical Exam		HIV test	
Pap Smear		Chest X-ray	
Mammogram		EKG	
Digital Rectal Exam		STD Screen	
Colonoscopy		Cholesterol test	
TB test		Blood glucose	
Bone density test		Urinalysis	
Other physical exam		Fecal Occult Blood	
Other imaging test		Other test	

INDICATE ANY PAINFUL OR DISTRESSED AREAS:



Family Medical History

Has any family member had:	Yes	Which Relative and Age of Onset?	Doctor's Notes
Diabetes			
Severe allergies			
Stroke			
Heart Disease			
Heart Attack			
Blood Clots in Legs or Lungs			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Osteoporosis			
Hepatitis			
Thyroid Problems			
Colitis / Crohn's Disease			
Tuberculosis			
Has any family member had:	Yes	Which relative and Age of Onset?	Doctor's Notes
Birth Defects			
Alcohol or Drug Addiction			
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Uterine Cancer			
Other Cancer			
Mental Illness/Depression			
Alzheimer's Disease			
Other:			

Lifestyle and Social History

Habits	Yes	No	Details	Doctor's Notes
Current Tobacco Use			Packs per day:	
Past Tobacco Use			Packs per day:	
Quit Smoking			When?	
Alcohol consumption			Types: Drinks per week:	
Recreational Drug Use			Type:	
Treated for drug/alcohol abuse?			When?	
Seat Belt Use				
Caffeine Use (coffee, tea, cola)			Type: Cups per day:	
Regular Exercise			Types: How long and how frequent?	

Social	Yes	No	Details	Doctor's Notes
Happy with relationship status?				
Do you have a good support network of family and friends?			Who?	
What is your predominant emotion?				

Lifestyle
Do you enjoy your work? Yes No
Stress Level (please circle): Low Medium High
Stress Source (please circle): Money Job Family/Relationship Other (please describe)
What do you do to relieve stress?
Please rate your energy level on a scale from 1-10 (10 = highest energy)

Sleep	Yes	No	Details	Doctor's Notes
Problems falling asleep				
Problems staying asleep				
Regular bedtime?			Typical bedtime?	
Regular wake up time?			Typical wake up time?	
Wake rested in the morning?			Average hours of sleep per night?	
Dreams?				

Diet	Doctor's Notes
Do you follow a particular diet?	
Known food allergies/intolerances?	
What is your typical breakfast?	
What is your typical lunch?	
What is your typical dinner?	
Snacks?	
Desserts/Treats?	
How much water do you drink per day?	
What other fluids do you drink and how much per day?	
What is your current weight?	
What was your weight one year ago?	

Review of Systems

Please check if you currently have or have had in the past:

General	Never	Past	Current	Doctor's Notes
Weight loss or gain				
Fever or chills				
Fatigue				
Heat or Cold Intolerance				
Cold Hands and Feet				
Sweats or Night Sweats				
Excessive Thirst				
Skin	Never	Past	Current	
Dryness				
Eczema				
Rashes or Itching				
Sores				
Mole changes				
Hair or nail changes				
Easy Bruising				
Head	Never	Past	Current	
Headache				
Head Trauma				

Eyes	Never	Past	Current	
Blurred Vision				
Glasses or Contact Lenses				
Dry Eyes				
Eye Pain				
Glaucoma				
Discharge from Eyes				
Ears	Never	Past	Current	
Earaches				
Ringing in Ears				
Hearing Loss				
Nose	Never	Past	Current	
Sinus Congestion or Infection				
Bleeding				
Discharge				
Post Nasal Drip				
Mouth / Throat	Never	Past	Current	
Sores				
Bleeding Gums				
Toothaches / Cavities				
Hoarseness of Voice				
Recurrent/persistent sore throat				
Bitter or Metallic Taste in Mouth				
Lungs	Never	Past	Current	
Asthma				
Shortness of Breath				
Chest Pain or Tightness				
Persistent Cough				
Wheezing				
Bronchitis				
Emphysema				
Pneumonia				
Tuberculosis				
Cardiovascular	Never	Past	Current	
Heart Palpitations/Arrhythmia				
High Blood Pressure				
Low Blood Pressure				
Heart Murmurs				
Heart Disease				
	Never	Past	Current	
Heart Attack				
Stroke				
Pacemaker				
Blood Clots in Legs or Lungs				
Swelling (edema) of Feet/Legs				
Circulatory Problems				
Varicose Veins				
Peripheral Arterial Disease				

Gastrointestinal	Never	Past	Current	
Loss of or Excess Appetite				
Nausea or Vomiting				
Difficult or Painful Swallowing				
Eating Disorders				
Indigestion or Heartburn				
Ulcer				
Gas / Bloating				
Constipation				
Diarrhea				
Blood in Stool				
Mucus in Stool				
Undigested Food in Stool				
Black or Tarry Stool				
Colitis/ Crohn's Disease				
Hernia				
Hemorrhoids				
Anal Discomfort				
Gallbladder Disease				
Hepatitis (type)				
High Cholesterol / Lipids				
Liver Disease				
Urinary	Never	Past	Current	
Pain with Urination				
Increased Urinary Frequency				
Urinary Frequency at Night				
Incontinence				
Urinary Tract Infection				
Kidney Disease				
Musculoskeletal	Never	Past	Current	Doctor's Notes
Muscle Pain / Spasm / Strain				
Joint Pain / Sprain				
Osteoarthritis				
Rheumatoid Arthritis				
Osteoporosis				
Weakness				
Trauma / Swelling				
Endocrine	Never	Past	Current	Doctor's Notes
Diabetes				
Thyroid Disease				
Tremor				
Hormone Therapy				
Breast Tissue	Never	Past	Current	Doctor's Notes
Breast Lumps				
Breast Pain				
Nipple Discharge				
Blood / Lymphatic	Never	Past	Current	Doctor's Notes
Anemia				
Bleeding Tendencies				
Blood Transfusion				
Persistent Swollen Lymph Node				

Allergic / Immune	Never	Past	Current	
HIV / AIDS				
Cancer / Chemotherapy				
Autoimmune Disease				
Hay Fever / Asthma / Eczema				
Drug Allergies				
Food Allergies				
Environmental Allergies				
Neurologic				
Epilepsy/ Seizures/Convulsions				
Fainting				
Dizziness or Vertigo				
Problems with Speech				
Problems with Walking				
Problems with Coordination				
Paralysis / weakness				
Neurologic	Never	Past	Current	Doctor's Notes
Numbness				
Multiple Sclerosis				
Psychologic				
Anxiety				
Depression				
Chemical Dependency				
Phobias				
Memory Loss				
Mood Changes				
Psychiatric Care				

Female Health Information

Menstrual History				Obstetric History			
Age at first period:				Have you ever been pregnant?			
Date last menstrual period began:				Age at first pregnancy:			
Are your periods regular?				Number of pregnancies:			
Number of days between periods:				Number of living children:			
Number of days of menstrual flow:				Number of stillbirths:			
Heaviness of flow (number of pads or tampons in 24 hours):				Number of miscarriages:		Trimester of pregnancy?	
Color of flow:				Number of tubal pregnancies:			
Clots? (please circle)	Yes	No		Number of abortions:			
Pain with menstrual period?	Yes	No		Number of CEsasarian sections:			
Menopause?	Yes	No		Date of last pregnancy:			
Ovarian cyst?	Yes	No		Difficulty conceiving?	Yes	No	
Uterine fibroids?	Yes	No		Difficulty with pregnancy?	Yes	No	
Hysterectomy?	Yes	No	If yes, date:	Difficulty with labor and delivery?	Yes	No	
PMS Symptoms (circle all that apply): None				Difficulty with breast feeding?			
Bloating				Future OB plans?			
Breast Tenderness Acne Mood Swings Fatigue				Yes No			
Digestive Changes Headache Other:							
Vaginitis Symptoms		Never	Past	Current	Risk Factors		
Discharge					History of abnormal Pap smear?	Yes	No
Irritation / Itching					Did your mother take DES?	Yes	No
Vaginal Dryness					Do you do self-breast exams?	Yes	No
Odor					Do you have annual gynecological exams?	Yes	No
Pain with Sex					Hormone replacement therapy?	Yes	No
Trichomoniasis					History of sexually transmitted infections?	Yes	No
Bacterial Vaginosis (BV)					Use of birth control pills		
Yeast Infection					If yes, how long?		
Sexually Active							
Use safer sex practices							

Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Dr Mead will take a thorough case history, perform a physical examination, and on occasion take blood for laboratory investigation. If your case requires, the physical may include more specific examinations such as gynaecological, rectal, prostate or genital exams. As some of these services are not provided with Dr. Mead, an appropriate referral will be made to another health professional.

It is very important that you inform Dr. Mead immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise Dr. Mead if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by naturopathic medicine.

These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements, herbs and IV nutrients. Please advise Dr. Mead of any allergies you may have.
- Pain, bruising or injury from venipuncture or parental therapy.
- Muscle strains and sprains, disc injuries from spinal manipulation.
- Intravenous therapies run the risk of anaphylaxis, though in practice this is rare.
- Dr Mead is trained to handle emergencies should the need arise.

Cancellation Policy:

Dr Mead requires 24-hour notice of cancellation prior to an appointment. You will be charged the full cost of the visit if short or no notice is given.

I understand:

- **Dr Mead does not guarantee treatment results.**
 - **Dr Mead will explain to me the exact nature of any treatment provided and will answer any questions I may have.**
 - **I am free to withdraw my consent and to discontinue treatment at any time.**
 - **I must give 24-hour notice of cancellation prior to an appointment or I will be charged the full cost of the visit.**
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Patient Name: (please print name) _____

Signature of Patient or Guardian : _____ Date: _____