BALANCE medical center

FEMALE MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. These questions will help to identify underlying causes of illness and will also assist in formulating a treatment plan.

Please write clearly in black ink.

PERSONAL INFORMATION

First Name: Last Name:

Address:

City: Prov: Postal Code:

Home Phone: Work Phone:

Cell Phone: Email:

Date of Birth: mo / day / year Place of Birth:

Provincial Health Card Number:

Occupation: Referred by:

Marital Status: Number of Children:

Height: ft in Weight: lbs

Name of your Family Doctor:

Who to contact in case of emergency:

Phone Number:

Relationship to emergency contact:

CURRENT MEDICAL ISSUES

Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

Describe Problem	Mild/Moderate/ Severe	Treatment Approach	Success
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate

PAST MEDICAL AND SURGICAL HISTORY

Do you have or have you ever had any of the following? Please write approximate date.

Illness	☑	Date	Comments
Recurrent Sinusitis			
Chronic Bronchitis			
Asthma			
Emphysema			
Tuberculosis			
Angina			
Heart Attack			
Arrhythmia			
High Blood Pressure			
Stroke			
Heart Failure			
Rheumatic Fever			
High Cholesterol			
Hepatitis			
Gallstones			
Irritable Bowel Syndrome			
Crohn's or Colitis			
Chronic Kidney Disease			
Diabetes			
Thyroid Disease			
Epilepsy			
Anemia			
DVT (Blood clots in legs)			

Illness cont'd	☑	**Date**	**Comments**
Chronic Fatigue Syndrome			
Cancer (Specify type)			
Other:			
Injuries	☑	**Date**	**Comments**
Head Injury/Concussion			
Back/Neck Injury			
Broken bones (describe)			
Other:			
Diagnostic Studies	☑	**Date**	**Comments**
CT Scan (specify number and body part)			
Barium Studies			
Bone Density Scan			
Mammogram			
Colonoscopy			
MRI (specify body part)			
Surgical History	☑	**Date**	**Comments**
Appendectomy			
Tonsillectomy			
Gall Bladder/Cholecystectomy			
Hysterectomy			
Hernia			
Prostate			
Other (describe)			
Other (describe)			

MEDICATIONS AND SUPPLEMENTS

What medications are you taking now? Include over-the-counter medications.

Medication Name	Dosage/Frequency	Date Started

Are you allergic to any medications? ◯ Yes ◯ No
If yes, please list medication and the nature of the reaction you had to it:

List all vitamins, minerals, and other nutritional supplements you are taking now.

Vitamin/Mineral/Supplement Name	Dosage/Frequency	Date Started

CURRENT MEDICAL SYMPTOMS

Please indicate if these symptoms occur presently **or** have occurred in the past 6 months.

General	Mild	Mod-erate	Severe
Cold hands & feet			
Cold intolerance			
Heat intolerance			
Difficulty falling asleep			
Early waking			
Night waking			
Daytime sleepiness			
Flushing			
Fatigue			
Head, Eyes & Ears			
Conjunctivitis			
Ear fullness			
Ear ringing/buzzing			
Headache			
Hearing problems			
Migraine			

Musculoskeletal	Mild	Mod-erate	Severe
Joint pain			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle weakness			
Tension headache			
TMJ problems			
Mood/Nerves			
Anxiety			
Panic attacks			
Depression			
Suicidal thoughts			
Irritability			
Fainting			
Dizziness (spinning)			
Light-headedness			
Difficulty with memory			

Mood/Nerves cont'd	Mild	Mod-erate	Severe
Difficulty concentrating			
Numbness			
Eating			
Anorexia			
Bulemia			
Binge eating			
Can't gain weight			
Can't lose weight			
Salt craving			
Carbohydrate craving			
Skin Problems			
Acne			
Dark circles under eyes			
Easy bruising			
Eczema			
Psoriasis			
Herpes – genital			
Hives			
Shingles			
Skin cancer			
Vitiligo			
Chronic itching			

Digestion	Mild	Mod-erate	Severe
Bleeding gums			
Bloating			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking lips			
Diarrhea			
Dry mouth			
Fissures			
Heartburn			
Hemorrhoids			
Intolerance to:			
Lactose			
Gluten			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice			
Nausea			
Persistent Lymph Nodes			
Neck/Groin/Armpits			

FAMILY HISTORY INFORMATION

Are there any significant illnesses in your family history? If so, please indicate the condition and family relation. Please include up to and including maternal and paternal grandparents.

Relation	Illnesses
Father	
Mother	
Sibling	
Sibling	
Maternal grandfather	
Maternal grandmother	
Paternal grandfather	
Paternal grandmother	

DIETARY INFORMATION

Please carefully list an average day's food consumption. Try to be as detailed as possible, and include the number of glasses of water, juice, coffee, or other beverages in the space provided. Exact portion sizes need not be listed.

Breakfast (_____ am)

Lunch (_____ am / pm)

Dinner (_____ pm)

Snacks: Mid Morning:

Mid Afternoon:

After Dinner:

Daily Beverages:

Do you have any food cravings? Yes No
If yes, do you crave sweets? _____ Breads/pastas? _____ Salty foods? _____

Are you on a special diet? Yes No
If yes, please specify:

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? Yes No

If yes, please list the particular food or supplement associated with your symptoms.

Please fill in the chart below:

Bowel Movements			
Frequency	☑	**Consistency**	☑
More than 3 times a day		Soft and well formed	
2 to 3 times a day		Small and hard	
1 time a day		Loose but not watery	
3 to 5 times a week		Alternating between hard	
2 or fewer times a week		& loose/watery	
		Pencil thin	
Intestinal Gas			
Daily		Present with pain	
Occasionally		Foul smelling	
Excessive		Little odor	

How often do you now drink alcohol?
Do not drink alcohol
No longer drinking alcohol
0-5 drinks per month
Average 1-6 drinks per week
Average 7-10 drinks per week
Average >10 drinks per week

Have you ever had a problem with alcohol? Yes No
If yes, please indicate time period (month/year): from to

Have you ever used recreational drugs? Yes No
Which drugs presently

Which drugs in the past

Have you ever used tobacco? Yes No
If yes, number of years as a nicotine user Amount per day Year quit

LIFESTYLE INFORMATION

With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.) Example: Wendy, age 7, sister

Are you currently, or have you ever been, married? Yes No
If so, when were you married? Spouse's occupation
When were you separated? Never _____
When were you divorced? Never _____

Have you or your family recently experienced any major life changes? Yes No
If yes, please comment:

Have you experienced any major losses in life? Yes No
If so, please comment:

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. .
Have you been involved in abusive relationships in your life?
Yes No If yes, as a child? _____ As an adult? _____ Presently? _____

How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	N/A
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your boyfriend/girlfriend					
With your children					
With your parents					
With your spouse					

What are your hobbies and leisure activities:

Do you exercise regularly? ○ Yes ○ No
If so, how many times a week? When you exercise, how long is each session?

_____ 1x
_____ 2x
_____ 3x
_____ 4x or more

_____ ≤ 15 min
_____ 16-30 min
_____ 31-45 min
_____ ≥ 45 min

What type of exercise is it?

Jogging		Walking		Hiking	
Cycling		Snow sports		Water sports	
Strength training		Aerobics		Martial Arts	
Other (comment)					

OBSTECTRICAL/GYNECOLOGICAL INFORMATION

Have you ever been pregnant? ○ Yes ○ No
Number of term births
Number of preemies
Number of abortions
Age at first term birth
Number of miscarriages

Did you have problems with pregnancy? ○ Yes ○ No
If yes, high blood pressure _____ diabetes _____ Other ___

Did you breastfeed? ○ Yes ○ No
If yes, how long?

Date of last Pap smear _____ Normal ○ Abnormal ○
Date of last Mammogram _____ Normal ○ Abnormal ○

Have you every used birth control pills? ◯ Yes ◯ No
If yes, when was your last use?
If yes, how may years did you use?

Date of last menstrual period

Are your periods regular? ◯ Yes ◯ No

How many days long is your menses cycle (from the start of one period to the start of the next)?

Do you have premenstrual symptoms? ◯ Yes ◯ No ◯ Not applicable
If yes, describe

If postmenopausal, do you have symptoms of hormone deficiency?

Hot flushes		Night sweats		Sleep disturbance	
Weight gain		Poor memory		Brain Fog	
Low libido		Breast tenderness		Vaginal dryness	
Anxiety		Palpitations			

Do you have or have you ever had:

Breast cysts		Breast lumps		Ovarian cysts	
Fibroids		Endometriosis		Vaginal odor	
Vaginal itch		Pain with intercourse		Excessive/prolonged menstrual bleeding	

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