Northeast Ohio Institute of Functional Medicine

Your Center for Hope and Healing

Personal Information

Name

Address | City | State

Zip | ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Birth Date | Age | Height | Weight

Sex at Birth | Place of Birth

Home Phone | Work

Cell | Email

Employer | Occupation

Referred By

Preferred Pharmacy & Phone #

Emergency Contact

Please check appropriate box(es)

☐ African American ☐ Native American ☐ Mediterranean

☐ Hispanic ☐ Caucasian ☐ Northern Europe

☐ Asian ☐ Other

Insurance Information

Primary Insurance

Insurance Address

Policy #

Group #

Policy Holder's Name

Relationship

Policy Holder's Birthdate

Phone #

Policy Holder's Employer

Insured Address (if different)

Financial Information

Credit Card Number

Expiration Date

Name on Card

I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of possible insurance benefits.

Please Sign & Date

Release of Information

I authorize the release of any medical information necessary to process future claims.

Please Sign & Date

Patient Consent Form

Federal requirements regarding the privacy of information for health care patients went into effect April 2003. The Health Insurance Portability and Accountability Act (H.I.P.A.A.) requires that all medical providers, insurance companies, and others put into place controls to ensure that your personal medical information remains confidential. We are requesting that you sign this form to allow us to share protected health information with other physician's offices, your hospital and insurance company.
By signing this form, you consent to our use and disclosure of protected health information about you, for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provide information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Please Sign and Date

Patient Full Name | Date of Birth

Appointments and Cancellation Policy

To schedule an appointment at NEOIFM we require a credit card on file.

New patient appointments require 50% of the new patient fee as a deposit to reserve your appointment.

We require a notice at least 48 business hours prior to a new patient appointment via email or voice mail to cancel.

New patient cancellations without notice or missed appointments will incur a $350 cancellation fee. The fee will be deducted from the deposit.

Follow up appointments require a minimum of two business days notice to avoid a $225 cancellation fee.

Please be aware that our normal business hours are
Monday, Tuesday, Thursday, and Friday 9am to 5 pm.
Our office is closed on Wednesday and the weekends.

We appreciate your efforts and look forward to serving you.

Please sign below to verify that you understand and accept our billing policies.

Please Sign and Date

Authorization to Release Information to Family Members

Many of our patients allow immediate family members, such as a spouse, parent or others to call our office and request the results of tests, procedures, and medical information. Under the requirements of H.I.P.A.A., we are not allowed to give this information to anyone without your consent. If you wish to have your information released to family members, you must fill out the information below. Signing this form will give consent to release information to family members indicated. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the Northeast Ohio Institute of Functional Medicine to release to the following individuals. (Please initial)

_____ All Medical Information (No Demographics)

_____ All Medical Information & Demographics

_____ Lab Results

_____ Test Results Only

1.	Relationship to Patient
2.	Relationship to Patient

Please Sign and Date

Authorization to Leave Messages with Household Members/Answering Machine

It's sometimes necessary for our staff to leave telephone messages for our patients. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask the patient to call the Northeast Ohio Institute of Functional Medicine regarding an issue of concern. At no time will a representative of the Northeast Ohio Institute of Functional Medicine discuss your medical circumstance or condition, without your consent. This authorization will permit us to leave messages with members of your household in voicemail, or on your answering machine. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance to your prior consent. Please check the appropriate locations for which we have your permission to leave messages.

☐ Home ☐ Work ☐ Cell ☐ Email

Patient Name

Please Sign and Date

Northeast Ohio Institute of Functional Medicine
Dorothy S. Sprecher, M.D.

Adult Medical Questionnaire

Thank you for your interest in The Northeast Ohio Institute of Functional Medicine, Your Center for Hope and Healing. As a new patient, 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. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions help to identify underlying causes of illness and will also assist us to formulate a treatment plan. We appreciate your time and attentions and look forward to helping you achieve a healthier you!

Chief Complaint / Reason for Visit:

Please list current and ongoing problems and provide other information as completely as possible

Describe Problem *Example: sinusitis*	**Mild/Moderate/Severe?**	**Treatment Approach & Results** *Example: herbs, acupuncture*

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

Do you have pets or farm animals? ☐ Yes ☐ No

If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Boarding

Adult Medical Questionnaire

Have you lived or traveled outside the United States? ☐ Yes ☐ No

If so, when and where?

As you look back over your life, list any events and experiences that have been of significance or caused major change in your life. *Examples: death of a close friend or relative, loss of a job.*

How important is religion or spirituality for you and your family's life?

Not at all important 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Extremely important

How much time have you lost from work or school in the past year?

☐ 0 - 2 days ☐ 3 - 14 days ☐ >15 days

Occupational history including Volunteer work:

Past Medical and Surgical History:

Illness/Conditions	When	Comments/Treatment
Anemia		
Arthritis, stiff joints, fibromyalgia, bursitis, tendonitis, gout, joint pain		
Asthma, wheezing, bronchitis, emphysema, short of breath, pneumonia, lung cancer		

Adult Medical Questionnaire

Past Medical and Surgical History Continued:

Illness/Conditions	When	Comments/Treatment
Atrial Fibrillation, heart disease, MI, heart surgery, murmur, palpitations, MVP, chest pain, angina, rheumatic fever, heart failure, pacemaker		
High cholesterol, high blood pressure/hypertension, stroke		
Diabetes, hypoglycemia, metabolic syndrome		
HIV/AIDS		
Cancer, Leukemia, Hodgkin's, Non-Hodgkin's Lymphoma		
Chronic Fatigue Syndrome, Mononucleosis		
Crohn's Disease, ulcerative colitis, Gallstone, gallbladder, hepatitis, IBS, kidney stones		
Epilepsy, convulsions, seizures, dementia		
Allergies, food intolerances, drug allergies, seasonal, hay fever, sinus, post nasal drip		
Thyroid disease		
Adrenal disease, Cushing's, Addison's		
Skin cancer, hives, acne, psoriasis, eczema		
Sleep apnea, insomnia		
Breast cancer, fibrocystic breasts		
Prostate disease		
Other:		

Adult Medical Questionnaire

Injuries	When	Comments/Treatment
Back injury		
Broken bones - describe		
Head injury		
Neck injury		
Other injuries - describe		

Diagnostic Studies	When	Comments/Treatment
Barium enema		
Bone scan		
CT scan of abdomen		
CT scan of brain		
CT scan of spine		
Chest X-Ray		
EKG		
Stress test/Echocardiogram		
Holter monitor		
Heart catheterization		
Liver scan		
Neck X-Ray		
NMR/MRI		

Adult Medical Questionnaire

Past Medical and Surgical History Continued:

Diagnostic Studies	When	Comments/Treatment
Colonoscopy		
Sigmoidscopy		
Upper GI series		
Pulmonary function study		
Other diagnostics studies		

Surgeries	When	Comments/Treatment
Appendectomy		
Dental Surgery		
Removal of Mercury, fillings		
Gallbladder		
Colostomy		
Hernia		
Hysterectomy		
Tonsillectomy		
Cosmetic/plastic surgery		
Reconstructive surgery		
Breast implants		
Other prosthesis		

Hospitalization and Medication

Hospitalizations: Where	When	For What Reason?

How often have you taken antibiotics?

☐ Infancy/childhood ☐ Teenage ☐ Adulthood

Name of last antibiotic and reason:	*Date(s) last taken:*

How often have you taken oral steroids?

☐ Never ☐ Occasionally ☐ Chronic

List any prescription medications you are currently taking:

Medication Name	Date Started	Dosage	For What Reason?

Medications and Allergy

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:

List all current vitamins, minerals, supplements and over the counter products:

Product Name	Date Started	Dosage	For What Reason?

Describe your childhood health experiences:

Frequent doctor visits	☐ Yes	☐ No
Sore throat, allergies, stomachaches	☐ Yes	☐ No
Missed a lot of school	☐ Yes	☐ No
Shy, withdrawn, isolated	☐ Yes	☐ No

Does strong odors affect you? Such as spray perfume? ☐ Yes ☐ No

If yes, how?

Adult Medical Questionnaire

Place a checkmark next to the food/drink that applies to your current diet:

Breakfast	Lunch	Dinner
☐ none	☐ none	☐ none
☐ bacon/sausage	☐ salad hot/cold	☐ legumes
☐ bagel/toast	☐ sandwich	☐ meat
☐ butter	☐ leftovers	☐ fish
☐ cereal hot/cold	☐ restaurant meal	☐ poultry
☐ coffee	☐ meat	☐ restaurant meal
☐ protein shake/bar	☐ poultry	☐ rice or pasta
☐ donut/pastry	☐ fish	☐ potatoes
☐ eggs	☐ soup	☐ nuts/seeds
☐ muffin	☐ veggies raw/cooked	☐ veggies raw/cooked
☐ oat bran/meal	☐ fruit	☐ fruit
☐ added sugar	☐ cottage cheese	☐ cottage cheese
☐ juice	☐ yogurt	☐ yogurt
☐ artificial sweetener	☐ nuts/seeds	☐ coffee
☐ tea	☐ soda/pop	☐ soda/pop
☐ water	☐ wine/beer/cocktail	☐ wine/beer/cocktail
☐ yogurt	☐ added sweetener	☐ added sweetener
☐ smoothie	☐ protein shake	☐ protein shake

Adult Medical Questionnaire

Food Reactions:

Food **Example: milk**	**Reaction** **Example: gas, diarrhea**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

How many times per week do you skip meals? _____

If so, which meals? _____

Do you feel better when you do not eat? ☐ Yes ☐ No

Please fill in the chart below regarding your bowel movements:

Frequency

- ☐ Multiple times in a day
- ☐ Once daily
- ☐ Every other day
- ☐ Only a few times per week

Additional Support

- ☐ I use fiber supplements regularly
- ☐ I use Laxatives
- ☐ I get colonics/colon hydrotherapy
- ☐ Other supplements: Vitamin C, Magnesium, tea, etc

Toxin Exposure/Detoxification

Do you drink alcohol? ☐ Yes ☐ No

What type? ☐ Beer ☐ Wine ☐ Cocktails ☐ Liquor

How often? ☐ Daily ☐ Weekends ☐ Infrequently ☐ Never

Have you ever had health consequences or addiction to alcohol? ☐ Yes ☐ No

If yes, indicate when and what happened:

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No

If yes, indicate how long you've been smoking or the year you quit:

Do you have mercury amalgam (silver) fillings? ☐ Yes ☐ No

Do you have artificial joints or implants? ☐ Yes ☐ No

If yes, please explain:

Example: hip replacement, breast implants, teeth

Do you feel worse at certain times of the year? ☐ Yes ☐ No

If yes, please specify:

☐ Spring ☐ Summer ☐ Autumn ☐ Winter

Have you, to your knowledge, been exposed to metal or chemicals at your job or in your home?

☐ Yes ☐ No

If yes, which ones?

☐ Lead ☐ Cadmium ☐ Arsenic ☐ Mercury ☐ Aluminum ☐ Other: _____

Psychosocial History

Hobbies and Leisure Activities

Do you exercise regularly? ☐ Yes ☐ No

How many times per week? ☐ 1x ☐ 2x ☐ 3x ☐ 4x or more

How long is each session? ☐ Less than 15 minutes ☐ 20-30 minutes ☐ 45 minutes or more

What type of exercise do you do?

☐ Jogging ☐ Cardio ☐ Pilates

☐ Walking ☐ Calisthenics ☐ Yoga

☐ Weight Training ☐ Running ☐ Other

What is the attitude of those close to your about your illness/health circumstances?

☐ Supportive ☐ Non Supportive

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No

If yes, please explain what kind and list treatment dates:

Are you currently or have ever been married? ☐ Yes ☐ No ***Date of Marriage:*** _____

Spouse's Occupation: _____

When were you widowed? _____

When were you separated? _____

When were you divorced? _____

When were you remarried? _____

Remarried Spouse's Occupation: _____

	Father	Mother	Brother/Sister	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Name								
Good Health								
Poor Health								
Deceased								
Write in Age or Mark Cause of Death:								
Alcoholism								
Allergies & Asthma								
Alzheimer's or Dementia								
Anemia								
Blood Clotting Issues								
Diabetes								
Cancer/Tumor								
Epilepsy/Seizures								
Genetic Disease								
Heart Disease								
High Blood Pressure								
Kidney/Bladder								
Anxiety/Depression								
Rheumatism or Arthritis								
Stomach/Bowel								
High Cholesterol								
Thyroid								
Health Patterns in extended family								
Other significant illness:								

Family History, for each family member, check the appropriate box that applies to their past and present health conditions. Fill out the chart.

Any other family history/comments we should know about?:

Symptoms

Please mark if you experience these symptoms Now (N) or if you previously had them in the past 6 months (P).
Please rate the following N for now or P for past 6 months.

Head, Eyes & Ears	Mild	Moderate	Severe
distorted smell	_____	_____	_____
ear fullness	_____	_____	_____
ear pain	_____	_____	_____
ear crusting	_____	_____	_____
headache	_____	_____	_____
hearing problems	_____	_____	_____
migraine	_____	_____	_____
vision problems	_____	_____	_____
conjunctivitis	_____	_____	_____
distorted taste	_____	_____	_____
ear noises	_____	_____	_____
ears ringing/buzzing	_____	_____	_____
eye pain	_____	_____	_____
hearing loss	_____	_____	_____
lid margin redness	_____	_____	_____
sensitivity to noises	_____	_____	_____

Musculoskeletal	Mild	Moderate	Severe
calf cramps	_____	_____	_____
foot cramps	_____	_____	_____
joint pain	_____	_____	_____
joint stiffness	_____	_____	_____
muscle twitches	_____	_____	_____
eye twitches	_____	_____	_____
arms or legs twitch	_____	_____	_____
muscle weakness	_____	_____	_____
tendonitis	_____	_____	_____
TMJ issues	_____	_____	_____
back muscle spasm	_____	_____	_____
chest tightness	_____	_____	_____
joint deformity	_____	_____	_____
joint redness	_____	_____	_____
muscle pain	_____	_____	_____
muscle spasms	_____	_____	_____
muscle stiffness	_____	_____	_____
neck muscle spasms	_____	_____	_____
tension headache	_____	_____	_____

Symptoms

Please mark if you experience these symptoms Now (N) or if you previously had them in the past 6 months (P).
Please rate the following N for now or P for past 6 months.

Mood/Nerves	Mild	Moderate	Severe
agoraphobia	_____	_____	_____
audio hallucinations	_____	_____	_____
depression	_____	_____	_____
difficulty w/ balance	_____	_____	_____
difficulty w/ judgement	_____	_____	_____
difficulty w/ memory	_____	_____	_____
fainting	_____	_____	_____
irritability	_____	_____	_____
numbness	_____	_____	_____
panic attacks	_____	_____	_____
seizures	_____	_____	_____
tingling	_____	_____	_____
visual hallucinations	_____	_____	_____

Eating	Mild	Moderate	Severe
binge eating	_____	_____	_____
can't gain weight	_____	_____	_____
carbohydrate craving	_____	_____	_____
poor appetite	_____	_____	_____
bulimia	_____	_____	_____
can't lose weight	_____	_____	_____
carbohydrate intolerance	_____	_____	_____
salt craving	_____	_____	_____
disordered eating	_____	_____	_____

Sleep	Mild	Moderate	Severe
cold hands & feet	_____	_____	_____
daytime sleepiness	_____	_____	_____
early waking	_____	_____	_____
fever	_____	_____	_____
heat intolerance	_____	_____	_____
nightmares	_____	_____	_____

Sleep	Mild	Moderate	Severe
cold intolerance	_____	_____	_____
difficulty falling asleep	_____	_____	_____
fatigue	_____	_____	_____
flushing	_____	_____	_____
night waking	_____	_____	_____
no dream recall	_____	_____	_____

Symptoms

Please mark if you experience these symptoms Now (N) or if you previously had them in the past 6 months (P).
Please rate the following N for now or P for past 6 months.

Digestion	Mild	Moderate	Severe	Digestion	Mild	Moderate	Severe
anal spasms	_____	_____	_____	blood in stools	_____	_____	_____
bleeding gums	_____	_____	_____	canker sores	_____	_____	_____
bloating of abdomen	_____	_____	_____	constipation	_____	_____	_____
burping	_____	_____	_____	dentures-poor chewing	_____	_____	_____
cold sores	_____	_____	_____	difficulty swallowing	_____	_____	_____
lip corner cracking	_____	_____	_____	excessive gas	_____	_____	_____
diarrhea	_____	_____	_____	reflux	_____	_____	_____
dry mouth	_____	_____	_____	hemorrhoids	_____	_____	_____
fissures	_____	_____	_____	intolerance to dairy	_____	_____	_____
heart burn	_____	_____	_____	intolerance to corn	_____	_____	_____
intolerance to lactose	_____	_____	_____	intolerance to fatty foods	_____	_____	_____
intolerance to gluten	_____	_____	_____	liver disease/jaundice	_____	_____	_____
intolerance to yeast	_____	_____	_____	mucus in stools	_____	_____	_____
lower abdominal pain	_____	_____	_____	periodontal disease	_____	_____	_____
nausea	_____	_____	_____	strong stool odor	_____	_____	_____
sore tongue	_____	_____	_____	upper abdominal pain	_____	_____	_____
undigested food stool	_____	_____	_____	fissures	_____	_____	_____
vomiting	_____	_____	_____	heart burn	_____	_____	_____
bad teeth	_____	_____	_____	intolerance to lactose	_____	_____	_____
bloating-lower abdomen	_____	_____	_____	intolerance to gluten	_____	_____	_____

Symptoms

Please mark if you experience these symptoms Now (N) or if you previously had them in the past 6 months (P).
Please rate the following N for now or P for past 6 months.

Skin Problems	Mild	Moderate	Severe
acne on back	_____	_____	_____
acne on face	_____	_____	_____
athlete's foot	_____	_____	_____
cellulite	_____	_____	_____
ears get red	_____	_____	_____
eczema	_____	_____	_____
hives	_____	_____	_____
lackluster skin	_____	_____	_____
oily skin	_____	_____	_____
patchy dullness	_____	_____	_____
rash	_____	_____	_____
sensitive to vbites	_____	_____	_____
shingles	_____	_____	_____
skin darkening	_____	_____	_____
thick calluses	_____	_____	_____
acne on chest	_____	_____	_____
acne on shoulders	_____	_____	_____
bumps on upper arm	_____	_____	_____
dark circles around eyes	_____	_____	_____
easy bruising	_____	_____	_____
vitiligo	_____	_____	_____

Skin Problems	Mild	Moderate	Severe
herpes - genital	_____	_____	_____
jock itch	_____	_____	_____
moles w/ changes	_____	_____	_____
pale skin	_____	_____	_____
psoriasis	_____	_____	_____
red face	_____	_____	_____
sensitive to poison ivy	_____	_____	_____
skin cancer	_____	_____	_____
strong body odor	_____	_____	_____
Skin Itching	**Mild**	**Moderate**	**Severe**
anus	_____	_____	_____
ear canals	_____	_____	_____
feet	_____	_____	_____
legs	_____	_____	_____
nose	_____	_____	_____
roof of mouth	_____	_____	_____
skin in general	_____	_____	_____
arms	_____	_____	_____
eyes	_____	_____	_____
hands	_____	_____	_____
nipples	_____	_____	_____

Symptoms

Please mark if you experience these symptoms Now (N) or if you previously had them in the past 6 months (P).
Please rate the following N for now or P for past 6 months.

Skin Itching	**Mild**	**Moderate**	**Severe**
genitals	_____	_____	_____
scalp	_____	_____	_____
throat	_____	_____	_____

Skin Dryness	**Mild**	**Moderate**	**Severe**
eyes	_____	_____	_____
feet - cracking	_____	_____	_____
feet	_____	_____	_____
feet - peeling	_____	_____	_____
hair	_____	_____	_____
hair unmanageable	_____	_____	_____
hands	_____	_____	_____
hands - peeling	_____	_____	_____
hands - cracking	_____	_____	_____
scalp	_____	_____	_____
skin in general	_____	_____	_____
mouth/throat	_____	_____	_____
dandruff	_____	_____	_____

Nails	**Mild**	**Moderate**	**Severe**
bitten	_____	_____	_____
curve up	_____	_____	_____
fungus-fingers	_____	_____	_____
pitting	_____	_____	_____
ridges	_____	_____	_____
thickening nails	_____	_____	_____
white spots/lines	_____	_____	_____
brittle	_____	_____	_____
frayed	_____	_____	_____
fungus-toes	_____	_____	_____
ragged cuticles	_____	_____	_____
soft nails	_____	_____	_____
thickening of toenails	_____	_____	_____

Symptoms

Please mark if you experience these symptoms Now (N) or if you previously had them in the past 6 months (P).
Please rate the following N for now or P for past 6 months.

Respiratory	Mild	Moderate	Severe
bad breath	_____	_____	_____
dry cough	_____	_____	_____
hay fever - spring	_____	_____	_____
hay fever - Fall	_____	_____	_____
hay fever - Summer	_____	_____	_____
hay fever - seasonal	_____	_____	_____
hoarseness	_____	_____	_____
nose bleeds	_____	_____	_____
sinus fullness	_____	_____	_____
snoring	_____	_____	_____
wheezing	_____	_____	_____
bad odor in nose	_____	_____	_____
productive cough	_____	_____	_____
nasal stuffiness	_____	_____	_____
post nasal drip	_____	_____	_____
sinus infection	_____	_____	_____
sore throat	_____	_____	_____
winter stuffiness	_____	_____	_____

Cardiovascular	Mild	Moderate	Severe
angina/chest pain	_____	_____	_____
heart attack	_____	_____	_____
high blood pressure	_____	_____	_____
mitral valve prolapse	_____	_____	_____
phlebitis	_____	_____	_____
varicose veins	_____	_____	_____
breathlessness	_____	_____	_____
heart murmur	_____	_____	_____
irregular pulse	_____	_____	_____
palpitations	_____	_____	_____
swollen ankles/feet	_____	____	_____

Lymph Nodes	Mild	Moderate	Severe
Enlarged/tender neck	_____	_____	_____
Enlarged/tender nodes	_____	_____	_____

Symptoms

Please mark if you experience these symptoms Now (N) or if you previously had them in the past 6 months (P). Please rate the following N for now or P for past 6 months.

Male Reproductive	Mild	Moderate	Severe
genital discharge	_____	_____	_____
genital pain	_____	_____	_____
infection	_____	_____	_____
poor libido	_____	_____	_____
ejaculation issues	_____	_____	_____
impotence	_____	_____	_____
lumps in testicles	_____	_____	_____
Urinary	**Mild**	**Moderate**	**Severe**
bed wetting	_____	_____	_____
UTI	_____	_____	_____
kidney stones	_____	_____	_____
pain/burning	_____	_____	_____
prostate infection	_____	_____	_____
hestitancy	_____	_____	_____
kidney disease	_____	_____	_____
leaking/incontinence	_____	_____	_____
orostate enlargement	_____	_____	_____
urgency	_____	_____	_____

Female Reproductive	Mild	Moderate	Severe
breast cysts	_____	_____	_____
breast tenderness	_____	_____	_____
poor libido	_____	_____	_____
fibroids	_____	_____	_____
genital discharge	_____	_____	_____
genital itch	_____	_____	_____
breast lumps	_____	_____	_____
ovarian cyst	_____	_____	_____
endometriosis	_____	_____	_____
infertility	_____	_____	_____
vaginal odor	_____	_____	_____
vaginal pain	_____	_____	_____

Symptoms

Premenstrual	Mild	Moderate	Severe	Menstrual	Mild	Moderate	Severe
bloating	_____	_____	_____	cramps	_____	_____	_____
carbohydrate cravings	_____	_____	_____	irregular periods	_____	_____	_____
constipation	_____	_____	_____	scanty periods	_____	_____	_____
diarrhea	_____	_____	_____	heavy period	_____	_____	_____
increased sleep	_____	_____	_____	no period	_____	_____	_____
breast tenderness	_____	_____	_____	spotting in between	_____	_____	_____
chocolate craving	_____	_____	_____				
decreased sleep	_____	_____	_____				
fatigue	_____	_____	_____				
irritability	_____	_____	_____				

Optional:

Have you had HIV testing? ☐ Yes ☐ No

Do you suspect that you are at risk for HIV/AIDS? ☐ Yes ☐ No

Thank you for your time and attention to this questionnaire.
Please contact us if you have any questions prior to your first visit.
We look forward to working with you!

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Your Center for Hope and Healing

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