

## **THE WOMEN'S WELLNESS INITIATIVE**

In conjunction with Hooper's Pharmacy and Vitamin Shop,  
88 Lakeshore Road East, Mississauga ON, L5G 1E1 905-278-4242

### **GENERAL HEALTH AND REPRODUCTIVE HISTORY QUESTIONNAIRE**

Consultation Date: \_\_\_\_\_

#### **INSTRUCTIONS TO OUR CLIENTS**

One of the most important parts of the medical record your health care provider keeps for you is a health history concerning your past and present health problems, and any personal information which might affect the state of your health.

Your answers will be treated confidentially as are all parts of your visit. Please return this questionnaire on the date of your visit.

Take all the time you need to complete this questionnaire. Answer each question as best you can by filling in the information asked for or by putting an "X" in the appropriate space. Choose the answer that to each question which in your mind comes closest to applying to you.

If there is any question you have difficulty answering, just circle the question. You can discuss it with the consultant when you return the questionnaire.

After you have completed your questionnaire at home, be sure to bring it with you so that you and your consultant can go over your answers during your appointment within a confidential setting.

Any changes which have occurred since you last filled out the questionnaire should be noted.

**ALL INFORMATION IS TREATED AS CONFIDENTIAL.  
THANK YOU**

**PART A –GENERAL INFORMATION**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone No.: \_\_\_\_\_ Work Phone No.: \_\_\_\_\_

Occupation: \_\_\_\_\_ Full-time: \_\_\_ Part-time: \_\_\_ Retired: \_\_\_

Unemployed: \_\_\_ Other: \_\_\_

Living Situation: Spouse: \_\_\_ Alone: \_\_\_ Partner: \_\_\_ Friend(s): \_\_\_ Parent(s): \_\_\_ Child(ren): \_\_\_

Other: \_\_\_

Status: Married \_\_\_ Single: \_\_\_ Separated: \_\_\_ Divorced: \_\_\_ Widowed: \_\_\_

Pet(s): \_\_\_\_\_

How did you hear about Bio-identical Hormone Replacement Therapy?

Ad: \_\_\_ Another Client: \_\_\_ Courses/Seminars: \_\_\_ Physician/Health Care Practitioner: \_\_\_

Books/Articles: \_\_\_ Other: \_\_\_

Do you understand what Bio-Identical Hormone Replacement is? \_\_\_\_\_

What are your goals for Bio-Identical Hormone Replacements?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current/recent **Doctor** and/or health care providers: *Please complete Name, Address, Suit number (if any), Postal Code and Phone no..*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## PART B -PRESENT HEALTH HISTORY

### I. CURRENT MEDICAL PROBLEMS

Please list the diagnosis or medical conditions for which you have come to see a consultant.  
About when did they begin?

<u>Problems</u>	<u>Date Began</u>
_____	_____
_____	_____
_____	_____

### II. MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements)

PRESCRIPTION MEDICATION: OVER THE COUNTER vitamin, supplements, herbs etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### III. ALLERGIES AND SENSITIVITIES

List anything that you are allergic to such as certain foods, medications, dust, chemicals or soaps, household items, pollens, bee stings, etc.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### IV. GENERAL HEALTH AND HABITS

How is your overall health now? Health now: Poor:\_\_\_ Fair:\_\_\_ Good:\_\_\_ Excellent:\_\_\_  
How has it been most of your life? Health has been: Poor:\_\_\_ Fair:\_\_\_ Good:\_\_\_ Excellent:\_\_\_  
In the past year:

Has your appetite changed? Decreased:\_\_\_ Increased:\_\_\_ Stayed same:\_\_\_

Has your weight changed? Lost: \_\_\_lbs. Gained: \_\_\_lbs. Stayed same:\_\_\_

Are you thirsty much of the time? No:\_\_\_ Yes:\_\_\_

Has your overall energy changed? Decreased:\_\_\_ Increased:\_\_\_ Stayed same:\_\_\_

Do you usually have trouble sleeping? No:\_\_\_ Yes:\_\_\_

Do you get routine physical exercise? No:\_\_\_ Yes:\_\_\_ If Yes, how often? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

Do you use tobacco products? No:\_\_\_ Yes:\_\_\_ If yes, how many years? \_\_\_\_\_

How many each day? \_\_\_\_\_

Have you ever smoked? No:\_\_\_ Yes:\_\_\_ If yes, how many years? \_\_\_\_\_

Do you drink alcoholic beverages? No:\_\_\_ Yes:\_\_\_

I drink: \_\_\_Beers \_\_\_glasses of wine \_\_\_ounces of liquor per day.

How much coffee or tea do you usually drink? \_\_\_cups of coffee or \_\_\_cups of tea a day.

Caffeinated\_\_\_ Decaffeinated\_\_\_

DO YOU:	Rarely/Never	Occasionally	Frequently
Feel Depressed?	_____	_____	_____
Find it hard to make decisions?	_____	_____	_____
Lose your temper?	_____	_____	_____
Ever have suicidal thoughts?	_____	_____	_____
Use marijuana?	_____	_____	_____
Use "hard drugs"?	_____	_____	_____

Have you recently had any changed in your (if yes, please explain):

Marital status? No:\_\_\_ Yes:\_\_\_\_\_

Job or work? No:\_\_\_ Yes:\_\_\_\_\_

Residence? No"\_\_\_ Yes:\_\_\_\_\_

Financial status? No:\_\_\_ Yes:\_\_\_\_\_

Are you having any legal problems or trouble with the law? No:\_\_\_ Yes:\_\_\_\_\_

Seriously sick family members? No:\_\_\_ Yes:\_\_\_\_\_

Additional comments, questions or thoughts:

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## PART C – PAST HISTORY

### I. FAMILY HEALTH

Please give the following information about your immediate family:

Relationship:	Age, if living	Age at Death	State of health or cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____

Have any **blood relative(s)** had any of the following illnesses? If so, indicate relationship (mother, brother, etc.):

Illness:	Family Member(s):
Diabetes ____	_____
Cancer ____	_____
High Blood Pressure ____	_____
Heart Disease ____	_____
Mental Problems ____	_____
Suicidal Thoughts ____	_____
Stroke ____	_____

### II. HOSPITALIZATION, SURGICAL PROCEDURES

Please list all the times you have been hospitalized or had any surgical procedures performed.

Year: \_\_\_\_\_ Type of surgical procedure: \_\_\_\_\_

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### III. ILLNESS AND MEDICAL PROBLEMS

Please mark with an (x) any of the following illnesses and medical problems you have or have had and indicate the year each started. If you are not certain when an illness started, write down an approximate year.

Illness	(x)	Year
Thyroid trouble	___	_____
Allergies, asthma or hay fever	___	_____
High blood pressure	___	_____
Heart attack	___	_____
High cholesterol	___	_____
Heart palpitations	___	_____
Gallbladder trouble	___	_____
Kidney or bladder disease	___	_____
Headaches	___	_____
Stroke	___	_____
Arthritis	___	_____
Cancer or tumour	___	_____
Genital herpes	___	_____
Varicose veins	___	_____
Chronic fatigue	___	_____

## PART D – BODY SYSTEMS REVIEW

Please answer the following questions.

	Rarely/ Never	Occasionally	Frequently
1. Do you have to urinate more than 5 times a day?	_____	_____	_____
2. Do you get up at night to urinate?	_____	_____	_____
3. Do you ever loose urine when you strain, laugh, cough or sneeze?	_____	_____	_____
4. Do you:			
a. Every feel angry/irritable?	_____	_____	_____
b. ever feel overwhelmed?	_____	_____	_____
c. ever feel anxious?	_____	_____	_____
d. ever experience feeling bloated?	_____	_____	_____
e. ever have weight gain?	_____	_____	_____
f. ever having food cravings i.e chocolate, salt?	_____	_____	_____
g. ever feel tearful or cry easily?	_____	_____	_____
h. ever feel depressed or hopeless?	_____	_____	_____
i. ever have headaches?	_____	_____	_____
j. ever have a decreased interest in activities?	_____	_____	_____
k. ever have difficulty concentrating?	_____	_____	_____
l. have heavy menstrual periods?	_____	_____	_____
m. have painful menstrual bleeding?	_____	_____	_____
n. have any bleeding between periods?	_____	_____	_____
o. have any brown spotting/bleeding <i>before</i> your period? _____	_____	_____	_____
p. have any brown spotting/bleeding at the <i>end</i> of your period? _____	_____	_____	_____
q. have any unusual vaginal discharge or itching?	_____	_____	_____
r. ever have breast tenderness?	_____	_____	_____
s. have or ever had fibrocystic breasts?	_____	_____	_____
t. have or ever had discharge from your nipples? _____	_____	_____	_____
u. have any hot flashes?	_____	_____	_____
Night sweats?	_____	_____	_____
Vaginal dryness?	_____	_____	_____
Foggy thinking?	_____	_____	_____
Memory lapses?	_____	_____	_____
Sleep disturbance?	_____	_____	_____
Bone loss?	_____	_____	_____
Water retention?	_____	_____	_____
Candida infections?	_____	_____	_____
5. How many full term pregnancies? _____			
Spontaneously aborted (miscarriage): _____			
Induces abortion: _____			
6. How many children born alive? _____			
7. Have you ever taken birth control pills? Presently: _____ Past: _____ How long? _____			
8. What was the date of your last period? Date: ____/____/____			
9. What was the date of your last Pap Smear? Date: ____/____/____			
10. What was the date of your last bone density test? Date: ____/____/____			
11. When was your last mammogram? Date: ____/____/____			

12. Have you ever had Thermography? Yes:\_\_\_ No:\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_

Check here if you wish to discuss any special problem with your consultant... \_\_\_\_\_

Rarely/Never    Occasionally    Frequently

- |  |       |       |       |
|--|-------|-------|-------|
| 13. Do you have dry skin or brittle fingernails?                           | _____ | _____ | _____ |
| 14. Do you have a tendency to have cold hands?                             | _____ | _____ | _____ |
| 15. Do you have a tendency to have cold feet?                              | _____ | _____ | _____ |
| 16. Do you have a low tolerance to cold weather?                           | _____ | _____ | _____ |
| 17. So you have leg cramps or pain in your<br>thighs or legs when walking? | _____ | _____ | _____ |
| 18. Do you feel tired in mid afternoon (between 3:00pm and 5:00 pm)?       | _____ | _____ | _____ |
| 19. Do you sometimes have swollen ankles or feet?                          | _____ | _____ | _____ |

Additional comments, questions or thoughts:

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## PART E – DIET AND NUTRITIONS

1. How many meals do you eat each day? \_\_\_\_meals each day.
2. Do you usually eat breakfast? No: \_\_\_\_ Yes: \_\_\_\_
3. Do you snack? \_\_\_more than once a day \_\_\_usually daily \_\_\_rarely
4. Do you consider yourself \_\_\_underweight \_\_\_overweight \_\_\_just right?
5. Do you add salt to your food at the table? \_\_\_almost always \_\_\_sometimes \_\_\_rarely
6. Do you crave sweets? No:\_\_\_ Yes:\_\_\_\_
7. Do your crave chocolate? No:\_\_\_ Yes:\_\_\_\_
8. Check the frequency you eat the following types of foods:

	More than once daily	Daily	3 times weekly	Once weekly	Twice monthly	Less or never
a. Whole grain or enriched bread or cereal						
b. Milk, cheese or other dairy products						
c. Eggs						
d. Meat, Poultry, Fish						
e. Beans, Peas or other legumes						
f. Dark green or deep yellow vegetables						

Additional comments or questions:

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**Thank you** for completing this questionnaire. Please review for skipped questions, sign your name on the space at the bottom and bring it with you on the day of your consultation. If you wish to add any information, please write it in the space provided above.

**ALL INFORMATION IS CONFIDENTIAL.**

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_