INITIAL HEALTH SURVEY FOR WOMEN

Please answer all questions. If not applicable, write "NA". Please return to:

Francis Holistic Medical Center, P.C.
360 West Boylston Street, Suite 107
West Boylston, Massachusetts 01583
508-854-1380 FAX: (508) 854-0446

PLEASE COMPLETE ALL INFORMATION, IF POSSIBLE

Name _____ Date of Initial Visit Scheduled _____
Address_____
_____
Home Phone _____ Birthday _____ Age _____ Sex _____
Driver's License #_____ Business Phone _____
Occupation _____ Employer _____
Work Address _____
_____
Insurance Company _____ Social Security # _____
Education: Number of years completed _____ Religious Affiliation _____
Marital Status: _____ Household Members & Ages _____
_____
Spouse's Name _____ Spouse's Occupation _____
Spouse's Employer _____ Spouse's Business Phone _____
Names and Addresses of other physicians _____
_____
_____
Names, Addresses, and Phone numbers of nearest living relatives:
_____ Relationship_____
_____ Relationship _____
In emergency notify:
_____ Phone _____
Please specify who referred you to this office (Circle source)
Family, Friend, School Physician, Clergy, Court, Self, Other:
Name _____ Phone _____
Address _____

THIS QUESTIONNAIRE MAY OR MAY NOT APPEAR TO RELATE TO YOUR EASON FOR COMING TO THIS OFFICE. PLEASE ANSWER THE QUESTIONS, WHICH DO APPLY TO YOU AS COMPLETELY AS POSSIBLE. MANY TIMES, PROBLEMS ARE MORE COMPLEX THAN THEY SEEM AT FIRST, AND YOUR ANSWERS WILL HELP US EVALUATE YOU MORE COMPLETELY.

THANK YOU.

CmM-Qst-3WI (P)

FOR OFFICE USE ONLY

I. CHIEF COMPLAINT AND PRESENT ILLNESS

Chief Complaint (main symptoms) _____
_____
When did it begin and how has it progressed _____
_____
_____
_____
_____
_____
_____
What treatment have you had and by whom _____
_____
_____
_____
When and where did you have your last complete physical _____
_____
What were the results _____

List current medical problems
_____
_____
_____

List past medical problems
_____
_____
_____

What do you want to achieve with your first visit to the office?
_____
_____
_____

Check (✓) if you have ever had? When? Childhood illness:

____ lapse of consciousness	_____	
____ convulsions	_____	_____
____ history of allergy	_____	_____
____ stroke	_____	Hospitalizations:
____ high blood pressure	_____	when where what for
____ heart attack	_____	_____
____ diabetes	_____	_____
____ arthritis	_____	_____
____ emphysema	_____	_____
____ pneumonia	_____	

II. DRUG HISTORY

What drugs do you take on a regular basis? What strength and how much?

_____

_____

List any drug or injection, which caused a reaction and list the symptom caused:

Drug	Symptoms	Drug	Symptoms
_____		_____	
_____		_____	

Have you ever reacted to : Dental anesthetics ____; Tetanus antitoxin ___; Tetanus Toxoid ___; Iodides ___; X-ray contrast media ___; Penicillin ___ other _____?

If you have had any of the following tests place an (X) in the appropriate box, and, if you can, give the year you last had them:

Year	Tests	Year	Tests
_____	( ) Chest X-Ray	_____	( ) Gallbladder X-Ray (cholecystogram)
_____	( ) Kidney X-Ray (pyelogram)	_____	( ) Electrocardiogram
_____	( ) G.I. Series	_____	( ) T.B. Tests
_____	( ) Colon X-Ray (Barium Enema)		

III. MEDICAL HISTORY - Please indicate the severity of each symptom by placing a number from 1 to 10, with 10 being the most severe, in the blank. Judge the severity by the frequency and intensity of the symptom; 10 is considered almost unbearable. Leave blank if not applicable.

III. A. SKIN

Indicate any past or current skin symptoms with P (for Past), C (for Current), or I (for Intermittent) in the space after the symptom:

_____ shingles	_____ itching	_____ bruising
_____ cracking	_____ fungus	_____ rash
_____ edema	_____ brittle nails	_____ boil
_____ blanching	_____ oiliness	_____ scalp problems

Has your skin ever been bothered by contact with any substances? _____

Which substances? _____

III. B. HEADACHES AND CEREBRAL

What type of intensity of pain do you have? Please check (✓) (0-10)

_____ constant _____ constriction _____ excruciating _____episodic _____ severity

Where is your head pain and how does it come and go? Please check (✓)

_____ lasts seconds, minutes, hours, days
_____ returns regularly
_____ upper teeth
_____ back of eye
_____ worse if lying down
_____ clears without treatment

With what is your headache associated? Please check (✓)

_____ tearing/swelling of eye _____inflamed eye _____visual disturbance _____nausea
_____ nasal blockage/running _____ neck/shoulder pain _____ abdominal pain

Are your headaches preceded or worsened by: Please check (✓)

_____ humidity _____ intense light _____ eye strain _____ noise
_____ odors _____ muscle strain _____ anxiety _____ motions/infections
_____ arguments _____ overheating _____ foods

When does your headache usually occur? Please check (✓)

_____ when lying down _____ spring _____ summer _____ fall _____ winter

At what age did headache first occur? _____

Check (✓) what applies to you:

_____ can keep working _____ require eye covering ____ require bed rest
_____ cannot keep working _____ require hospitalization ____ pressure to head

Have you ever had?

_____ head injury _____ encephalitis when? _____

Do you know any causes of your headaches? Yes _____ No _____ If yes, explain _____
What medications and how much of each do you take daily for headache? _____
_____

III. C. <u>EYES</u> – Give a number for the severity (1 through 10); leave blank if not applicable.
Indicate every symptom you have if your eyes trouble you:

_____ sties
_____ irritated
_____ mucus in eyes
_____ twitching lids
_____ swelling both lids
_____ glaucoma
_____ blurred / double vision
_____ crusting lids
_____ puffy under eyes
_____ dark circles
_____ sensitive to light
_____ cataracts/see halos
_____ wear contact/glasses
_____ pain

Are your eye symptoms present all year round? Yes _____ No _____
Which is your worst season?

III. D. EARS

Please indicate every symptom that applies to your ears with a number from 1 to 10 to indicate the severity. Leave blank if not applicable.

_____ hearing loss	_____ frequent infections	_____ fluid/draining in ears
_____ dizziness	_____ pain/pressure/stuffed up	_____ crusting inside
_____ itching inside	_____ ringing/roaring	_____ other

III. E. NOSE Please indicate severity from 1 – 10. Leave blank if not applicable.

_____ itches	_____ bleeds	_____ sinus infections
_____ blocks	_____ post nasal drip	_____ require nose drops/spray
_____ sneeze	_____ runs	_____ no sense of smell
_____ polyps	_____ other	

Are these symptoms present all during the year? Yes_____ No_____ Which is your worst season?

Check (✓) when symptoms are worse:

_____ upon arising	_____ after meals	_____ after medicines
_____ upon lying down	_____ cold weather	_____ dry weather
_____ hot weather	_____ humid weather	_____ other

III. F. MOUTH AND THROAT

Please indicate severity from 1 – 10. Leave blank if not applicable.

_____ snore	_____ sleep with mouth open	_____ difficulty swallowing
_____ hoarse	_____ canker sores	_____ cracking lips/corners
_____ bad breath	_____ tongue swollen	_____ throat itches
_____ bad taste	_____ throat clearing	_____ neck glands swell
_____ lips swell	_____ wear dentures	_____ grind teeth in sleep
_____ chapped lips	_____ fever blisters	_____ throat closed
_____ sore throat/tongue	_____ lose voice	_____ other

II G CARDIAC AND RESPIRATORY – Please indicate the severity from 1 to 10 of every symptom that applies. Indicate any symptoms with P (for Past), C (for Current), or I (for Intermittent) after the listed symptom. Otherwise, leave blank.

_____ wheeze	_____ coughs	_____ frequent infections
_____ frequent colds	_____ croup	_____ tight/heavy chest
_____ ankle swelling	_____ short of breath	_____ heart enlargement
_____ murmurs	_____ skipped/rapid heart beats	_____ night sweats
_____ chest pain	_____ other	_____ pneumonia ____ times

Which is your main symptom: _____ Check (✓) when this symptom is worse:

_____ morning	_____ afternoon	_____ evening
_____ spring	_____ summer	_____ fall
_____ winter	_____ year round	_____ other

Which medications relieve you best?_____ How soon?_____ For how long?_____
How far can you walk vigorously before becoming short of breath? _____
List your maximum weight:_____ Minimum weight: _____ Desired weight: _____
Do you smoke?_____ Did you ever smoke? _____ How many packer per day? _____
When did you stop? _____
Do you exercise regularly_____ What type _____ How often _____
Do you consider yourself to be under (low, moderate, or high) levels of stress?

III. H. GASTROINTESTINAL/ DIGESTIVE Indicate the severity, from 1 to 10, of each symptom, which applies to you. Indicate any symptoms with P (for Past), C (for Current), or I (for Intermittent) after the listed symptom. Otherwise, leave blank.

_____ intestinal gas	_____ stool/foul odor	_____ on special diet
_____ indigestion	_____ frequent nausea/vomiting	_____ diarrhea/constipation
_____ bloody/tarry stools	_____ bloating	_____ ulcer
_____ anal itching/pain	_____ poor/good appetite	_____ gall bladder trouble
_____ re-taste food	_____ mucous in stool	_____ burning stomach relieved by eating

III I URINARY AND GENITALIA – Indicate the severity, from 1 to 10, of each symptom, which applies. Indicate any symptoms with P (for Past), C (for Current), or I (for Intermittent) after the listed symptom. Otherwise, leave blank.

_____ frequent urination	_____ difficulty urinating	_____ bed wetting
_____ itching	_____ bladder disease	_____ weak stream
_____ kidney disease	_____ infections	_____ pass blood
_____ lumps/pain swelling	_____ had or have cancer	_____ unsatisfactory sexual relations
_____ spouse being treated for infection		

III. I. 1. WOMEN'S ISSUES

_____ number of pregnancies	_____ births premature	_____ menopause
_____ number of births	_____ caesarians	_____ miscarriages/abortions
_____ taking hormone/hot flashes		

Breasts

_____ breast soreness before/ during periods
_____ breast cysts or lumps
_____ breast soreness not related to periods
_____ had breast biopsy
_____ had mastectomy
_____ nipple discharge

Menses

_____ age at onset
_____ use douches
_____ use I.U.D.
_____ use foam/diaphragm
_____ ovulation pain
_____ tense before/during
_____ regular/irregular periods
_____ am now pregnant
_____ had D & C
_____ use lubricants
_____ backaches
_____ dizzy before/during
_____ heavy/scant flow
_____ have cramps
_____ fibroids
_____ weight increase
____ depressed before/during
_____ had hysterectomy

III. I. 2. HERPES HISTORY

Are you subject to : Fever blisters (cold sores) ____; Shingles ____; Genital herpes____
On what part of your body do they occur?_____ When did the attacks first begin?_____
How frequently do they occur?_____ How long do the attacks usually last?_____
Do the attacks follow any pattern of recurrence? ____ List the treatments you have used._____

IV. PSYCHOLOGICAL HISTORY – Indicate severity, from 1 to 10, for every symptom which applies. Indicate "when" for any symptoms with P (for Past), C (for Current), and I (for Intermittent) in the space after the symptom. Otherwise, leave blank.

Symptom	When	Symptom	When
_____ often unhappy	_____	_____ frequently keyed up or jittery	_____
_____ feel "lost in time"	_____	_____ startled by sudden noises	_____
_____ incessant talker	_____	_____ considered a nervous person	_____
_____ am a workaholic	_____	_____ extremely shy or sensitive	_____
_____ numbness	_____	_____ misunderstood by others	_____
_____ profuse sweating	_____	_____ am being controlled by other forces	_____
_____ hyperactive	_____	_____ have seriously considered suicide	_____
_____ go to pieces easily	_____	_____ often unable to perform at work	_____
_____ sleep problems	_____	_____ unable to coordinate muscles	_____
_____unable to concentrate	_____	_____ feeling of hostility	_____
_____ have had visions	_____	_____ been addicted to a drug	_____
_____ have heard voices	_____	_____ feel withdrawn	_____
_____ frustration/anger	_____	_____ restless legs	_____
_____ loss of memory	_____	_____ often break out in cold sweats	_____
_____ irritable/aggressive	_____	_____ feel groggy	_____

Grade the extent to which you have these qualities: 0 = none, - = slight, 2 = moderate, 3 = average, 4 = great.

Love____ Joy____ Peace____ Patience____ Kindness____ Gentleness____ Faith ____
Self-control ____ Trust ____ Strength ____
In what do you have faith?_____ Trust? _____
What is the source of your strength? To what do you owe these qualities?

V. NUTRITIONAL HISTORY – Indicate the number of times consumed with, x1, x2, etc. under the appropriate column. Use only one column for each food item and leave blank if the food is not consumed.

FOOD	DAILY	WEEKLY	MONTHLY
Alcohol (type)			
Carbonated beverages			
Ice cream			
Candy			
Beef			
Bacon / sausage			
Butter (pat)			
Margarine (pat)			
Cold breakfast cereal			
Chicken			
Fish			
Raw fruit			
Bran			
Soy / tofu			
Rice			
Potato			
Tomato			
Green vegetables			
Eggs (1)			
Yogurt (8 oz.)			
Cheese (2 oz.)			
Pastries / cookies			
Catsup			
Honey (tblsp.)			
Sugar (tsp.)			
Coffee			
Tea, regular			
Tea, herbal			
Instant breakfast cereal			
Raw vegetables			
Salad			
Bread			
Milk			
Yellow vegetables			
Citrus			

Do you use:_____ Canned Food _____ Salt _____ Fried Food _____ White Bread _____ Whole Wheat or Whole Grains

Please check (✓) the appropriate heading below: (1) None, (2) Moderate, (3) A Lot.

Eats excessively when bored or depressed
Gulps food
Fights weight gain
Eats foods the patient know are "bad" for him/her
Eats and runs
Chews thoroughly
Reads & appreciates labels

Do you prefer: beer_____; scotch_____; wine _____; gin _____; vodka _____; rum _____; variety ____?

List all the foods you have ever avoided because they bother you:

VI. FOOD HISTORY – Indicate the severity of each symptom, from 1 to 10. Otherwise, leave blank. Indicated any symptoms with P (for Past), C (for Current), or I (for Intermittent), in the space after the symptom.

Do you have:

_____ excessive hunger	_____ special diet	_____ excessive weight loss/gain
_____ eat daytime/bedtime snacks	_____ cook from "scratch"	_____ bothered by food odors
_____ use convenience food	_____ crave drinks /foods	_____ eat "junk" food
_____ use exotic foods	_____ other	

As an infant or child, did you ever have:

_____ food/beverage intolerance	_____ leg aches	_____ mood disturbances
_____ poor appetite	_____ fussiness	_____ wet the bed
_____ constipation/diarrhea	_____ failure to thrive	_____ skin rash
_____ constant hunger	_____ night sweats	_____ stomachaches/gassiness
_____ learning problem	_____ other	

Is there a family history of allergies or food intolerance? _____
Are most of your meals: at home _____; at restaurants _____; gourmet _____?
Do you mostly eat foods that are: fresh_____; canned ____; frozen _____ packaged _____?
What is your favorite or most enjoyed food and beverage? _____

VII. MEDICAL HISTORY

Print the names of your relatives, living or deceased. Place an (X) in the appropriate column below for any illnesses that you or the relatives listed have had.

Father _____
Mother _____
Brothers/Sisters _____
_____
Children _____
_____
Grandparents _____

	Yours	Your Father	Your Mother	Your Bro/Sis	Your Children	Your Grandparents
Allergies	( )	( )	( )	( )	( )	( )
Anemia	( )	( )	( )	( )	( )	( )
Arthritis	( )	( )	( )	( )	( )	( )
Asthma	( )	( )	( )	( )	( )	( )
Bleeding	( )	( )	( )	( )	( )	( )
Bruising	( )	( )	( )	( )	( )	( )
Cancer	( )	( )	( )	( )	( )	( )
Convulsions	( )	( )	( )	( )	( )	( )
Diabetes	( )	( )	( )	( )	( )	( )
Drinking	( )	( )	( )	( )	( )	( )
Drug Problems	( )	( )	( )	( )	( )	( )
Eczema	( )	( )	( )	( )	( )	( )
Emphysema	( )	( )	( )	( )	( )	( )
Heart Trouble	( )	( )	( )	( )	( )	( )
Hepatitis	( )	( )	( )	( )	( )	( )
High Blood Pressure	( )	( )	( )	( )	( )	( )
Frequent Infections	( )	( )	( )	( )	( )	( )
Kidney Problems	( )	( )	( )	( )	( )	( )
Mental Illness	( )	( )	( )	( )	( )	( )
Migraine	( )	( )	( )	( )	( )	( )
Abnormal Periods	( )	( )	( )	( )	( )	( )
Psoriasis	( )	( )	( )	( )	( )	( )
Pneumonia	( )	( )	( )	( )	( )	( )
Polio	( )	( )	( )	( )	( )	( )
Prostate	( )	( )	( )	( )	( )	( )
Rheumatic Fever	( )	( )	( )	( )	( )	( )
Stomach Problems	( )	( )	( )	( )	( )	( )
Stroke	( )	( )	( )	( )	( )	( )
Thyroid Problems	( )	( )	( )	( )	( )	( )

If appropriate, comment of any of the above.