

Patient Name: \_\_\_\_\_

Date Form Completed: \_\_\_\_\_ DOB: \_\_\_\_\_

## General Patient Questionnaire – No Pelvic Pain

### Health Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

### Hormone Concerns:

1. \_\_\_\_\_
2. \_\_\_\_\_

### MEDICATION ALLERGIES AND SENSITIVITIES

*Please list prescription medications, environmental, latex allergies or sensitivities. Foods will be listed on another page.*

Allergen	Reaction

Menarche (age when periods began)	Number of times pregnant	Number of deliveries	Number of Vaginal or C-Section deliveries	Number of Babies over 9 lbs	Episiotomy or Tears	Number of Living Children	Number of Miscarriages (M) Still Born (SB) or Pregnancy Terminations (PT)
			V: C:		E: T:		M: SB: PT:

Have you had any of the following organs removed, if so when:

<input type="checkbox"/> Uterus ____/____/____	<input type="checkbox"/> Right Ovary ____/____/____	<input type="checkbox"/> Left Ovary ____/____/____	<input type="checkbox"/> Appendix ____/____/____	<input type="checkbox"/> Gallbladder ____/____/____
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**CURRENT MEDICATIONS and SUPPLEMENTS**  
(include vitamins, minerals, fatty acids and herbals)

Please list all current medications

Name	Dose	Amount	Frequency

IMMUNIZATIONS: (list with dates)


Smoker

Drink Alcohol

Other drugs:

**DIAGNOSTIC TESTS AND PROCEDURES AND DATES PERFORMED: CIRCLE ANY ABNORMAL LABS**

<input type="checkbox"/> PAP Smear ____/____/____	<input type="checkbox"/> Abnormal PAP ____/____/____	<input type="checkbox"/> Last Annual Exam ____/____/____	<input type="checkbox"/> Colonoscopy ____/____/____	<input type="checkbox"/> Glucose Testing ____/____/____
<input type="checkbox"/> Mammogram ____/____/____	<input type="checkbox"/> Bone Density Scan ____/____/____	<input type="checkbox"/> Insulin Resistance Testing ____/____/____	<input type="checkbox"/> Thyroid Testing ____/____/____	<input type="checkbox"/> Lipids (cholesterol) ____/____/____

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## PAST MEDICAL HISTORY

### PREVIOUS SURGICAL PROCEDURES

*Please list all of your surgeries in chronological order, starting with the most recent procedure.  
Please attach pages if more space is needed.*

Date	Hospital	Procedure	Is your Operation Report attached?

**Hospitalizations (excluding surgery and childbirth)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Injuries (falls, back injury, head injury, accidents, etc. )** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medical Illnesses (past and present)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**PAST HEALTH CARE PROVIDERS**

*What physicians or non-physicians health care providers have you previously seen for treatment?*

Name of Provider	Address	Phone/Fax	Are you sending Medical Records from this provider?

**REVIEW OF SYSTEMS:** *Check negative or all that apply*

Your Perspective of your health is:  Excellent  Good  Fair  Poor

<b>Allergic/ Immunological</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Pollen Allergy <input type="checkbox"/> Food Allergy	<input type="checkbox"/> Dust Allergy <input type="checkbox"/> Mold Allergy	<input type="checkbox"/> Autoimmune Disease
<b>General Health</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Low Grade Fever
<b>Head, Ears, Nose, Mouth and Throat</b>	List Problems:			
<b>Cardiovascular</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Pre-Hypertension	<input type="checkbox"/> Swelling Ankles <input type="checkbox"/> Known Murmur <input type="checkbox"/> Hypertension	<input type="checkbox"/> Palpitation <input type="checkbox"/> Fluttering Sensation <input type="checkbox"/> Irregular Heart Beats
<b>Respiratory</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma	<input type="checkbox"/> Coughing Blood <input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of Breath

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<b>Gastrointestinal</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Pain	<input type="checkbox"/> Nausea & Vomiting
		<input type="checkbox"/> Constipation	<input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Craving sweets
		<input type="checkbox"/> Bloating	<input type="checkbox"/> Discomfort	
<b>Genitourinary</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Low Sex Drive	<input type="checkbox"/> Pain with Urination
		<input type="checkbox"/> Frequency	<input type="checkbox"/> Urgency	<input type="checkbox"/> Incomplete Emptying
		<input type="checkbox"/> Interstitial Cystitis	<input type="checkbox"/> Incontinent	
<b>Musculoskeletal</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Joint Pain
<b>Skin</b>		Do you have a dermatologist? Y/ N	Any problems?	
<b>Breast</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Painful Breast(s)	<input type="checkbox"/> Discharge	<input type="checkbox"/> Last Evaluation: _____
		<input type="checkbox"/> Lumps	<input type="checkbox"/> Masses	
<b>Neurological</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Passing Out	<input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness
<b>Psychiatric</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Crying	<input type="checkbox"/> Depression	<input type="checkbox"/> Suicide Attempt
		<input type="checkbox"/> Bipolar	<input type="checkbox"/> Obsessive-Compulsive Disorder	<input type="checkbox"/> Schizophrenia
		<input type="checkbox"/> Attention Deficit Disorder		
<b>Endocrine</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Insulin Resistance
		<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Difficulty Concentrating
<b>Hematology/ Lymphatic</b>	<input type="checkbox"/> Negative	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Anemia
		<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Blood Transfusion	

## FAMILY HISTORY

(Mother=M, Father=F, Brother=B, Sister=S, Grandparent=G, Child=C, Aunt=A, Uncle=U)

If deceased, please list age and cause of death: \_\_\_\_\_

- |                              |                                |   |
|------------------------------|--------------------------------|---|
| 1. _____ Allergies           | 8. _____ Endometriosis         | 15. _____ Lupus   |
| 2. _____ Alcoholism          | 9. _____ Epilepsy              | 16. _____ Stroke  |
| 3. _____ Asthma              | 10. _____ Gall Bladder Trouble | 17. _____ Thyroid   |
| 4. _____ Auto Immune Disease | 11. _____ Heart Disease        | 18. _____   |
| 5. _____ Bleeding Disorder   | 12. _____ High Blood Pressure  | 19. _____   |
| 6. _____ Depression          | 13. _____ Hypoglycemia         | 20. _____ Cancer  |
| 7. _____ Diabetes            | 14. _____ Kidney               | Type/s: <input type="checkbox"/> Breast <input type="checkbox"/> Ovarian <input type="checkbox"/> Colon |
|                              |                                | Other:  |

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### SOCIAL HISTORY

Whom do you live with?	Were you ever the victim of sexual abuse as a child (<14 years old)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Education:	Have you ever been a victim of physical abuse by a family member? <input type="checkbox"/> Yes <input type="checkbox"/> No
What work are you trained for:	Have you been a victim of emotional abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
What type of work are you doing:	Have you received therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:

Do you react to foods?  Yes  No

Reactions: \_\_\_\_\_

What is your weekly exercise routine?

\_\_\_\_\_

Are you willing to change your lifestyle/habits to improve your health?  Yes  No

### WHAT ARE YOUR EXPECTATIONS OF TREATMENT?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Pelvic Pain and Urinary Frequency Questionnaire (PUF)**

*Circle the answer that best describes how you feel for each question*

		0	1	2	3	4	Symptom Score	Bother Score
1	a. How many times do you urinate during waking hours?	3 to 6	7 to 10	11 to 14	15 to 19	20+		
	b. If you get up at night to urinate, to what extent does it usually bother you?	0	1	2	3	4+		
3	a. If you are sexually active, do you now have or have you ever had pain or urgency to urinate during or after sexual intercourse?	Never	Occasionally	Usually	Always			
	b. If you are sexually active, has pain or urgency ever made you avoid sexual intercourse?	Never	Occasionally	Usually	Always			
4	a. Do you have pain associated with your bladder or in your pelvis, vagina, lower abdomen, urethra or perineum?	Never	Occasionally	Usually	Always			
5	a. Do you still have urgency shortly after urinating?	Never	Occasionally	Usually	Always			
6	a. When you have pain is it usually _____?	None	Mild	Moderate	Severe			
	b. How often does your pain bother you?	Never	Occasionally	Usually	Always			
7	a. When you have urgency, is it usually _____?	None	Mild	Moderate	Severe			
	b. How often does the urgency bother you?	Never	Occasionally	Usually	Always			

SYMPTOM SCORE

BOTHER SCORE

TOTAL SCORE