Schneck Integrative Medicine
Dr. Steve Windley / Sherry Arbuckle FNP-C

Phone# 812-523-5865
209 S. WALNUT ST. SEYMOUR INDIANA

FEMALE Personal History Form

Your appointment:

Name: _____ Date of Birth_____

PRIMARY CARE DOCTOR: _____ (DR WINDLEY IS NOT A PRIMARY CARE DOCTOR)

Major Symptoms

What brings you in today (major complaint)? _____
How frequent and severe are your symptoms? _____
How long have you had these symptoms? _____
What makes your symptoms worse? _____
What makes your symptoms better? _____
How do your symptoms interfere with your daily life, family life and career?

_____
_____
_____

Please list treatments you have received so far.

What test, medicines and consultations have been done so far?

_____
_____
_____

Have any of these treatments helped?

_____
_____

Were there any complications with any previous treatments?

_____
_____

Previous Medical History - Please check any conditions that apply to you.

☐ Hypothyroidism ☐ Poor sex drive ☐ Hypoglycemia ☐ Irritable bowel syndrome
☐ High cholesterol ☐ High blood pressure ☐ Macular degeneration
☐ Diabetes – Please give age of diagnosis _____
☐ Arthritis – Where are you affected? _____
☐ Coronary artery disease or heart disease ☐ Heart attack ☐ Stroke
☐ Other medical conditions _____

Surgical History – Please check all that apply.

☐ Adenoid removal ☐ Sinus surgery ☐ Tubes in ears ☐ Cataracts

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☐Gall bladder removal ☐ Hysterectomy ☐ Appendix removal ☐ Ovary removal
☐Joint replacement – Which joints? _____
☐ Other: _____ Blood type: _____

Medications/Supplements

Please list all prescriptions, over the counter medications, and supplements you currently take.

Medication/Supplement	Dose/Strength	How often you take it

List all known allergies to food, medications, and environment:

Allergy	Reaction

Social History

Who lives at home bedsides you?

_____

Are they healthy? _____

Marital status: _____ Number of children_____

Do you use any tobacco products? ☐ Yes ☐ No If yes, how many years? _____

Are you exposed to second hand smoke often? ☐ Yes ☐ No

Do you have any animals? ☐ Yes ☐ No If yes, what kind and how many?

_____

What is your current job? _____

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Has this or any past job put you around strong chemical or smoke? ☐Yes ☐ No
If yes, please explain:

_____
_____

Family Medical History
Please check all the appropriate boxes for your family member if any of the following apply.

	Mother	Father	Grandmother	Grandfather	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐

If yes to cancer please list what type of cancer and what age it was found:

_____
_____

Review of Systems - Please check all that apply to you.
Energy-activity
☐ Fatigue ☐ Get tired easily ☐ Wake up tired ☐ Sleep excessively ☐ Weight gain
☐ Put on weight easily ☐ Feel cold at temperatures that others are comfortable ☐Heat intolerance

Mouth, Throat, & Ears
☐ Stuffy nose ☐ Runny nose ☐Hay fever ☐ Frequent sinus infections
☐ Sore throat how many times per year? _____ ☐ Canker sores ☐ Ear infections
☐ Bad breath ☐ Ringing in ears ☐ Hearing loss ☐ Dizzy or lightheaded easily

Eyes
☐ Watering or itchy ☐ Cataracts ☐ Dry eyes ☐ Macular degeneration

Lungs
☐ Wheezing ☐ Asthma ☐ Bronchitis ☐ Chest congestion ☐ Difficulty breathing
☐ Shortness of breath ☐ ever had a chest x-ray

Cardiovascular
☐ High blood pressure ☐ Rapid heartbeat ☐ Irregular heartbeat ☐ Chest pain
☐Varicose veins ☐Snore while sleeping ☐Mitral valve prolapse ☐ Swollen feet

Digestive Tract
☐ Constipation ☐ Diarrhea ☐ Belching/gas ☐ Nausea ☐ Bad breathe

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☐ Heartburn/indigestion ☐ Bloating ☐ Poor sense of taste ☐ Hemorrhoids
☐ Blood in stool ☐ abdominal pain

Urinary tract/bladder
☐ Kidney/bladder infections ☐ burning upon urination ☐ Blood in urine
☐ Frequent urination ☐Incontinence ☐ Awake at night to urinate

Joints/Muscles
☐ Joint pain ☐ loss of muscle ☐ Muscle cramps ☐muscle aches ☐ joint swelling

Hormone Axis
☐ Hot flashes ☐ Night sweats ☐ Vaginal dryness/painful intercourse ☐ Tired constantly
☐ Low libido ☐ Fertility issues ☐ Tender breasts ☐ Premenstrual cramping ☐Heavy and/or irregular menses

☐ Weight gain in the belly ☐ weight gain in hips ☐ weight gain in spite of good diet?

☐ Cold hands ☐ Cold feet ☐ Dry skin ☐ Dry, coarse brittle hair
☐ Facial puffiness ☐ Feel more tired at rest then when you are active
☐ Low blood pressure ☐ Crave salt ☐ Crave sugar

Head, Emotions & Mind
☐ Headaches - Where does it bother you? _____
☐ Migraine Headaches – How frequent?
_____ ☐Tremor ☐ Restless legs
☐Numbness/tingling
☐ Poor sleep ☐Hyperactivity ☐ Reduction of memory ☐irritable
☐ Cannot think clearly/foggy thinking ☐ Reduction in concentration
☐ Anxious/nervous ☐Depressed ☐ Tearful ☐ Doubt ☐ Sleep light and restlessly
☐Irritability ☐I am stressed out or easily confused ☐ Obsessive/compulsive thoughts

Skin
☐ Cold hands ☐ Cold feet ☐ Dry skin ☐ Hives ☐ Psoriasis ☐ Acne
☐ Loss of hair ☐ Rashes/eczema ☐ Facial puffiness in the mornings
☐ Weak/brital nails ☐ Itching

Specific Health Questions - Please answer/explain as completely as possible.
How much caffeine do your drink daily?_____
How many diet drinks do you drink daily? _____
Do you crave or over consume:
☐ Sugar (sweets) ☐ Chocolate ☐ Caffeine ☐ Alcohol
Vegetables per day (#)? ____

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Chemical/Toxin Exposures:
☐Cigarette smoke ☐pesticides ☐ mold ☐ anti-perspirants
☐ Strong chemicals ☐ strong odors ☐ lead ☐PCBs ☐ Mercury ☐ ☐

Top Health Goals or Concerns you would like to focus on.

1._____
2._____
3._____