

Schneck Integrative Medicine  
Dr. Steve Windley

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209 S. WALNUT ST. SEYMOUR INDIANA

FEMALE Personal History Form

Your appointment:

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

Family 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?

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Please list treatments you have received so far.

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

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Have any of these treatments helped?

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Were there any complications with any previous treatments?

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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  
 Gall bladder removal     Hysterectomy     Appendix removal     Ovary removal

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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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____

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

Allergy	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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**Social History**

Who lives at home besides 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? \_\_\_\_\_  
Has this or any past job put you around strong chemical or smoke?  Yes  No

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If yes, please explain:

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**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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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**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 xray

**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 breath  
 Heartburn/indigestion     Bloating     Poor sense of taste     Hemorrhoids

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- 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. \_\_\_\_\_