SUNRISE
FUNCTIONAL MEDICINE

Female Health History Questionnaire

(Please Print CLEARLY in Black Ink)

Patient Name: _____ **Date:** _____

Birth Date: _____

Weight_____ **Height**_____ **Blood Pressure (if known)** _____

Primary Health Concerns:

_____

_____

_____

_____

_____

_____

_____

_____

_____

When did your health concerns begin?

_____

_____

_____

_____

Please use this space below to share additional information with us regarding your health concerns.

_____

_____

_____

_____

_____

_____

Occupation: _____

Please Describe Your Hobbies:

_____
_____
_____

Please list any current stressors in your life:

_____
_____
_____
_____
_____

Are there any specific events or occurrences that have or are currently impacting your health?

_____
_____
_____
_____
_____
_____

Pulmonary (Lung)

☐ NO PROBLEMS
☐ Asthma (wheezing)
☐ Chronic bronchitis
☐ Chronic cough
☐ Emphysema
☐ Tuberculosis
☐ Other _____

Cardiovascular Health

☐ NO PROBLEMS
☐ Hypertension (high blood pressure)
☐ Hypotension (low blood pressure)
☐ Heart Attack when? _____
☐ By-pass surgery when? _____
☐ Angioplasty (balloon) When _____
☐ Angina pectoris
☐ Tachycardia (rapid heart rate)
☐ MVP (Mitral Valve Prolapse)
☐ Congestive Heart Failure
☐ Heart Palpitations

Circulatory

☐NO PROBLEMS
☐ High Cholesterol
☐ High triglycerides (fats)
☐ Poor arterial circulation
☐Poor venous circulation
☐ Leg cramps
☐ Tired legs
☐ Swollen ankles
☐ Varicose veins
☐ Numbness of hand or leg
☐ Tingling sensations in hands or feet
☐ Leg ulcer

Gastrointestinal

☐ NO PROBLEMS
☐ Problems with digestion
☐ Acid indigestion/heartburn
☐ Belch after meals
☐ Bloating
☐ Stomach or duodenal ulcer
☐ Loss of appetite
☐ Rapid weight gain
☐ Rapid weight loss
☐ Overweight problem
☐ Nausea
☐ Pain
☐ Pancreas problems
☐ Hepatitis gall stones
☐ Jaundice (turning yellow)
☐ Recurring diarrhea
☐ Constipation (compact stools)
☐ Leaky gut syndrome

Urinary

☐NO PROBLEMS
☐ Recurrent bladder infections
☐ Renal (kidney) failure
☐ Stress incontinence
☐ Kidney stones
☐ Chronic fungal infections
☐ Weak adrenal glands
☐ Female menopause
☐ Other _____

Gynecologic

☐ NO PROBLEMS
☐ Menstrual periods every _____days
☐ Menstrual periods have ceased
☐ Premenstrual tension
☐ Vaginal yeast infections
☐ Water retention
☐ Urinary frequency
☐ Irregular menstrual cramping
☐ Painful menstrual cramping
☐ Breast masses
☐ Painful breast swelling
☐ Fibrocystic breasts
☐ Hot flashes
☐ Mood changes or irritability
☐ Loss of vaginal lubrication
☐ Fibroid tumors
☐ Polycystic ovary disease (PCO)
☐ Endometriosis
☐ Hysterectomy only
☐ Hysterectomy & removal of ovary(s)
☐ Tubal ligation
☐ Other _____

Obesity or Weight Loss

☐ Weight at 18? _____
☐ Weight gain or loss for how long?_____

Endocrine

☐ NO PROBLEMS
☐ Diabetes mellitus
☐ Insulin dependent
☐ Non- insulin dependent
☐ Thyroid dysfunction
☐ Low body temps
☐ Depression
☐ Overactive
☐ Underactive
☐ Dry skin
☐ Cold hands and/or feet
☐ Hair falling out or thinning

Skin

☐ NO PROBLEMS
☐ Chronic rash
☐ Eczema
☐ Psoriasis
☐ Skin cancer
☐ Dandruff or seborrhea
☐ Dry skin
☐ Oily skin
☐ Blemishes (acne)
☐ Lupus (SLE)
☐ Rosacea
☐ Fungal nail infections

Neuro-Psychiatric

☐ NO PROBLEMS
☐ Frequently nervous or anxious
☐ Depression
☐ Memory lapses or loss
☐ Decreased ability to concentrate
☐ Tension headaches/Migraine
☐ Sleep disturbances
    ☐ Trouble falling asleep
    ☐Trouble maintaining a restful sleep
☐ Chronic or recurrent dizziness
☐ Reduced vitality – chronic fatigue
☐ Other _____

Cancer (Past or Present) [very important]

☐ NO PROBLEMS
☐ lung
☐ Breast
☐ Prostate
☐ Brain
☐ Colon
☐ Stomach
☐ Skin
☐ Liver
☐ Bone
☐ Blood (leukemia
☐ Hodgkin's
☐ Bladder
☐ Other _____
When first diagnosed_____
Treatment _____
_____
Duration of Treatment _____
Last Checkup

Previous Prescription Medications:

Current Prescription Medications:

Anticoagulants? Since when _____

Sexual

☐ NO PROBLEMS
☐ Decreased in or loss of libido
☐ Decreased sexual vigor
☐ Orgasmic Problems

Rheumatoid, Joint and Back

☐ NO PROBLEMS
☐ Muscle pains
☐ Joint pains
☐ Neck pains
☐ Back pains
☐ Rheumatoid arthritis
☐ Lupus (SLE)
☐ Scleroderma
☐ Fibromyositis or Fibromyalgia
☐ Other

General Information:

☐ Past or Present Problems with:
☐ Medications
☐ Foods
☐ Soaps
☐ Clothing
☐ Vaccinations
☐ Multiple chemicals
☐ Trees
☐ Pollens
☐ Molds
☐ Animals
☐ Hay fever
☐ Asthma

Supplements Minerals, Herbs or Other

Operations or Hospitalizations

Reason	Dates

When were you last ill? _____
Diagnosis: _____

Dental

Orthodontics? Yes__ No__ If yes, explain

_____

☐ Braces

☐ If yes complications?

_____

☐ Amalgam fillings? How many? _____

☐ Root Canals? How many? _____

☐ Previous Gum Inflammation (gingivitis)

Social Habits

☐ Coffee: How many cups daily? _____

☐ Tea: How many cups daily? _____

☐ Smoking:

☐ Cigarettes How many? _____

☐ Cigars How many? _____

☐ Pipe How often? _____

☐ Alcohol

☐ Wine Intake per week?_____

☐ Beer Intake per week? _____

☐ Hard liquor Intake per week?_____

☐ Drugs

☐ Cocaine frequency _____

☐ Marijuana frequency _____

☐ Psychedelics frequency _____

☐ Other_____

Nutritional

☐ Do you eat Breakfast?

☐ Are you a vegetarian?

☐ Anorexia or bulimia

Example of Typical Daily Meals

Breakfast:_____
_____
Lunch: _____
_____
Dinner_____
_____
Snacks: _____
_____
Beverages: _____
_____

Sleep, Exercise and Relaxation:

How many hours of sleep? _____
Types of exercise_____
_____
_____
How often?_____
_____

Methods of Relaxation:
_____
_____
_____

WOMEN'S HEALTH & PRECONCEPTION QUESTIONNAIRE

FEMALE REPRODUCTIVE HISTORY

Are you currently pregnant? _____ How many weeks? _____

Date of last menstrual period? _____ Are your periods regular? _____

Days between periods: _____ Length of flow:_____

CHILDREN:

Sex / Age / Health problems (autism, asthma, allergies, congenital etc)

____ / ____ / _____

____ / ____ / _____

____ / ____ / _____

How many:

Perinatal Deaths: _____ Dates: _____

Miscarriages: _____ Dates: _____

Premature Births: _____ Dates: _____

Therapeutic Terminations: _____ Dates: _____

Stillbirths: _____ Dates: _____

Small baby at term: _____ Dates: _____

Problems during pregnancy:

_____

_____

☐ Did you breastfeed? How long?_____

☐ Problems with breastfeeding: Explain _____

INFERTILITY: (Y/ N) _____ Years: _____

Female: _____ Male: _____

Previous fertility treatments used:

Type: Duration/ no. times: Result:

_____ / _____ / _____

_____ / _____ / _____

_____ / _____ / _____

Any further information about past/present fertility treatment:

_____ _____

Screenings, Tests, Treatments

Date of last PAP: _____ Were the results normal? _____

History of abnormal PAPS?_____ Please explain the findings:_____

_____

_____

Date of last Mammogram/Thermography: _____ Abnormal findings? _____

Please explain :_____

_____

Date of last breast exam: _____ Abnormal findings? _____

Please explain: _____

_____

Are you taking HRT (hormone replacement therapy)? _____ What type and dosage? _____

_____

Recent Screenings/Exams

Date of last blood work: _____ Copy included with clinic paper work:_____

Date of last colonoscopy: _____ Abnormal findings: _____

Please explain: _____

Date of last Bone Density Scan (DEXA Scan): _____

Results: _____

Body Mass Index (BMI): _____ (Easy resources online to calculate BMI)

Diabetes Screening (Fasting glucose, insulin, Hgb A1c, glucose tolerance tests): _____

Please list the date and results: _____

_____

Thyroid Screening: _____ Date and Results? _____

_____

Additional tests, exams or procedures (please list and give dates):_____

_____

_____