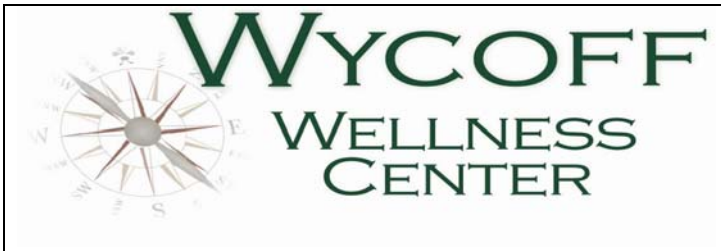

1226 Michigan Avenue
East Lansing, MI 48823
517-333-7270 – Phone
517-333-1801 – Facsimile
Email: info@wycoffwellness.com

Women's Questionnaire – Patient Information

Name:				
Address:				
City:			State:	Zip:
Phone:	Home:		Work:	
	Cell:		Email:	
Birthdate:		Age:		
What is your occupation?				

Primary Concern

1. What is your primary concern?

What kind of physicians have you seen for your health problem(s)?

Allergy Treatment

Yes	No	Please check all appropriate boxes				
		Have you been evaluated by an allergist?			What year?	
		Have you been tested for food allergies?				
		Have you been tested for inhalant allergies?				
		Did you receive allergy immunization injections?	No of Yrs.		Discontinued in?	
		Did you receive sublingual drops?	No of yrs.		Discontinued in?	

Past Medical History

Smoking

Yes	No	Please check all appropriate boxes		
		Do you currently smoke or did you ever smoke regularly	Pks per day:	No. of yrs:
		What year did you quit?	Year:	
		Do you consume caffeinated beverages regularly?	# Per day/ wk:	No of Yrs:
		Do you consume alcoholic beverages regularly?	# Per day/ Wk:	No of Yrs.
		Do you consume carbonated beverages regularly?	# Per day/ Wk:	No of Yrs.

Yes	No	Illnesses	Year	Yes	No	Illnesses	Year
		Cancer				Kidney Disease	
		Chronic Fatigue Syndrome				Lupus	
		Colitis				Mitral Valve Prolapse	
		Diabetes				Mononucleosis	
		Elevated Cholesterol				Multiple Sclerosis	
		Elevated Triglycerides				Oral yeast/Mouth Infection	
		Fibromyalgia				Pelvic Inflammatory Disease	
		Gall Bladder Disease				Pneumonia	
		Heart Disease				Seizures	
		Hepatitis				Sexually Trans. Disease	
						Shingles	
		Herpes				Sleep Apnea	
		HIV Positive				Stroke	
		Hypertension				Tuberculosis	
		Hyperthyroidism				Ulcerative Colitis	
		Hypothyroidism					
		Irritable Bowel Syndrome					

Lifetime Antibiotic Use:

Approximately how many times have you used antibiotics over the past:

1 Yr: No. x/yr.	5 yrs: No. x/yr.	10 y: No. x/yr.	20 yrs: No. x/yr.

Yes	No	Please answer all appropriate boxes		
		Was there a time in the past when you used antibiotics for 30 days or longer continuously for acne or other illness?		
		If yes, for what illness(es):		Year:
		How long did you take the antibiotics?		# Yrs:
		If for acne, did you take Accutane?	For how long?	

Drug Allergies: List all medications to which you are allergic.

1.	2.
3.	4.
5.	6.

Surgical Procedures:

What surgeries have you had?	Year (s)

How many times do you eat the following foods (can be daily, weekly, or less than weekly {0}

Food	Daily	Wkly	{0}	Food	Daily	Wkly	{0}
Wheat Products				Corn Products			
Dairy				Milk			
Beef				Chicken			
Soybeans				Starches			

Are there any foods to which you have an adverse reaction?	Symptom

Yes	No	Do you have any cravings for sweets, breads or salty foods?

Family History

Condition	Mother	Father	Siblings	Children	Grandparents
Alcoholism					
Arthritis					
Asthma					
Hay Fever					
Cancer					
Cirrhosis					
Diabetes					
Emphysema					
Epilepsy					
Gout					
Gall Bladder					
Heart					
High Blood Pressure					
Kidney Disease					
Kidney Stones					
Migraines					
Stroke					
Suicide					
Mental Health					
Thyroid					
T.B.					
Other					
Number of brothers					
Number of sisters					
Number of children					
Recent Immunizations:					
Do you get flu shots annually?					
When was your last tetanus shot?					
Have you had a pneumovax injection?					
Have you had a positive TB test?					

Review of Systems					
Headaches					
Yes	No		Number per Week	Number per Month	For how long?
		Do you have headaches?			
		What do you take to relieve your headache?			

Nose/Eyes						
Yes	No					
		Do you have recurrent sinus congestion?	For how long? (mos/yrs, etc.)			
		Fall	Winter	Spring	Summer	Year Round
		Do you have postnasal drainage?	During Meals?	After Meals?		
		Do you have an itchy nose or eyes?	For how long?			
		Do you sneeze often?				
		Fall	Winter	Spring	Summer	Year Round
		Is it worse when exposed to smoke or dust?				
		Do you snore?	For how long?	Months?	Years?	
		Do you have a poor or decreased sense of smell?	For how many years?			
		Do you have sinus infections?	Number per year?	How many years?		
		Do you have colds?	Number per year?	How many years?		

Ears				
Yes	No			
		Do you have ear infections?	Number per year	How many years
		Do you have poor/decreased hearing?	How many years?	
		Do you have dizziness or lightheadedness?		
		Number per week	Number per month	How many years?
		Do you have ringing in the ears?		
		Number per week	Number per month	How many years?

Mouth				
Yes	No			
		Do you develop canker sores or fever blisters?	Number per year?	Years?
		Have you had any wisdom teeth extracted?	How many?	
		Have you had any other teeth extracted?	How many?	
		Do you have any mercury amalgam fillings in your mouth?	How many?	
		Have you had a root canal?	How many?	

Throat				
Yes	No			
		Do you have sore throats?	Number per year	How many years?
		Have you ever had strep throat?	How many times?	
		Do you have difficulty swallowing on a general basis?	For how many years?	

Lungs				
Yes	No			
		Do you experience chest congestion and cough?	Times per yr.	How many yrs?
		Have you ever had bronchitis?	Times per year?	How many years?

Asthma						
Yes	No					
		Did you ever have asthma?		Times per year?		How many years?
		Fall	Winter	Spring	Summer	Year Round
		Do you have wheezing?		How Often?		How many years?
		Do you generally have shortness of breath?		How Often?		How many years?
		Have you ever been diagnosed with pneumonia?				What year?
Heart						
Yes	No					
		Do you ever feel your heart skip a beat?		How Often?		How many years?
		Do you have chest pain?		How often?		How many years?
		Is the pain sharp?	Stabbing?	Dull?		Aching?
		Does the pain radiate to	Neck?	Back?		Shoulders?
		How long does the pain last?				
		When you rise quickly, do you feel as though you might pass out?				
Gastrointestinal System						
Yes	No					
		Have you even been diagnosed with an ulcer?				
		If yes, was it stomach?	Duodenal?	What year(s)?		
		Do you use anti-ulcer medications?	If yes, what medication?			
		Do you have indigestion or heartburn?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
		Do you take anti-indigestion OTC medication for calcium?				
		Do you experience abdominal cramping?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
		Do you experience abdominal bloating?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
		Do you experience excessive belching?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
		Do you experience intestinal gas?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
		Do you ever have bright red blood in your stools?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
		Do you have diarrhea often?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
Urinary Tract						
Yes	No					
		Have you ever had bladder infections/kidney infections?				
		If yes, how often?	No. per week?	No. per month?		No. of years?
		Have you ever had kidney stones?	No. of times?	Yr. of last episode?		
		Do you have burning upon urination?				
		Do you have increased frequency or urgency of urination?				
		Do you have stress incontinence?				

Yeast/Skin Fungus					
Yes	No				
		Have you had problems with athlete's foot?		No. of times?	No. of years?
		Are your toenails discolored or unusually thick?		No. of years?	
		Have you ever had a vaginal yeast infection?		Number of times?	
		How many per yr?	No of yrs?	Between what years?	&
		Were your female yeast infections associated with antibiotic use?			

Skin							
Yes	No						
		Do you have eczema (dry, scaly skin) or skin rashes?				No. of years?	
		How many per year?	Location:				
		Do you know the cause of your rash?					
		Have you ever had hives?	How many times?	No. per year?			
		Between what ages?					
		Do you know the cause of your hives?					
		Do you have itchy skin?					
		Do you have puffy, pale or pasty skin?					
		Do you have dry skin?					
		Is it worse in the winter?					
Pets							
		Do you have pets?					
Yes	No	Type	Indoor	Outdoor	Type	Indoor	Outdoor
		Dog			Other		
		Cat			Other		
Thyroid							
Yes	No						
		Have you been diagnosed with a thyroid disorder?			Year diagnosed		
		Were you diagnosed with hyperthyroidism (high)?					
		Were you diagnosed with hypothyroidism (low)?					
		Did you ever take thyroid medication?			What year did you quit?		
		Name of medication			Dose mg.		
Malaise/Fatigue							
Yes	No						
		Do you feel you should have more energy?					
		What is your average energy level on a scale of 0 to 10 with 10 meaning brimming with energy and 1 or 2 meaning the inability to get out of bed?					
		ENERGY LEVEL 0-10 /10			For how many years?		

Fluid Retention				
Yes	No			
		Do you have swelling beneath your eyes or dark circles under your eyes?		
		How many times per month?	For how many years?	
		Do you have swelling of your face, hands, or feet?		
		How many times per month/	For how many years?	
		Is this swelling related to your periods?		
Cold Sensitivity				
Yes	No			
		Do you have cold hands or feet?		For how many years?
		Are you sensitive to the cold or get chilled easily?		For how many years?
Sweating				
Yes	No			
		Do the palms of your hands or feet perspire unusually?		For how many years?
		Do you have decreased perspiration?		For how many years?
Hair Condition				
Yes	No			
		Do you have coarse, normal or fine hair?		
		Have you ever had significant hair loss?		For how long?
		Do you have thinning hair?		
		Do you have loss of hair on the lateral 1/3 of the eyebrows?		
		Do you have brittle fingernails or ridging?		
Yes	No			
		Have you had significant weight gain?	No of pounds?	Since what year?
		Do you have difficulty losing weight?		For how long?
Cognitive Ability				
Yes	No			
		Do you ever feel that you have decreased mental sharpness?		
		Do you have a poor short-term memory?		
		For how many years have you had these problems?		

Mood		
Yes	No	
		Do you ever feel discouraged, blue or depressed more than 10% of the time?
		What percent of the time? For how many years?
		Have you had repeated, unexpected “attacks” during which you are suddenly overcome by intense fear or discomfort, for no apparent reason?
		Persistent, inappropriate thoughts, impulses or images that you can’t get out of your mind? (such as a preoccupation with getting dirty, worry about the order of things or aggressive or sexual impulses?
		Excessive worrying, for six months or more, about a number of events or activities?
		Fear of places or situations where getting help or escape might be difficult, such as in a crowd or on a bridge?
		Powerful and ongoing fear of social situations involving unfamiliar people?
		Have you had any major changes in your life recently? This could include things like: a wedding for a close family member, Purchase of a new house or moved recently A job change or stressful job Financial problems, Death or seriously ill family member or close friend, Divorce or separation

Bowel Function			
Yes	No	Do you have a bowel movement every day?	
		How many times per week do you have a bowel movement?	
		Do you alternate between constipation and diarrhea?	For how many years?

Joint Function											
Yes	No										
		Do you have pain in any joint(s)? (fibromyalgia?)						Which of the following joints?			
Yes	No		Yes	No		Yes	No		Yes	No	
		Neck			Lower Back			Shoulder			Elbows
		Wrists			Finger joints			Hips			Knees
		Ankles			Toe joints	Times per week?			For how many years?		

Muscle								
Yes	No	Do you have muscle weakness?						For how many years?
		Do you ever have generalized muscle pain?						For how many years?
		Do you any numbness or tingling in the extremities?						
		Do you ever have cramping in your muscles?						
Yes	No		Yes	No		Yes	No	
		Thighs?			Calves?			Feet?
Sleep								
Yes	No							
		Do you have insomnia or restless sleep?						For how many years?
		Do you feel tired after a full night's sleep?						For how many years?
		Do you have afternoon fatigue?						
		How many hours of sleep do you require per night?						

MENSTRUAL HISTORY – PREMENOPAUSAL QUESTIONS

Pregnancy			
Date of last normal menstrual period? (mo/day/yr)			
At what age did you enter puberty?			
How many pregnancies?		Live births?	Miscarriages?
Date of last child's birth?			Your age then?
Yes	No		
		Did you have difficulty becoming pregnant?	
		Did you ever receive infertility treatment?	What kind?
Birth Control			
Yes	No		
		Have you had bilateral tubal ligation?	If yes, when?
		Are you currently using an IUD?	
		Have you ever taken Depo-Provera?	
		Did you ever take birth control pills?	
		If yes, for how long?	Date you discontinued BCP?
		Are you currently taking any female hormones (progesterone or estrogen)?	
		If yes, which ones?	For how long?
Pap Smear			
Yes	No		
		Have you had an abnormal pap smear?	If yes, when?
		Was your most recent pap smear normal?	Date of pap?
Menstrual Periods			
Yes	No		
		Do your menstrual periods occur at the same time each month?	
		If no, what is the shortest number of days between periods?	
		What is the longest number of days between periods?	
		How long have your menstrual cycles been irregular?	Months? Yrs?
		Were your menstrual cycles ever regular?	
		How many days do your periods last?	Days?
		Are your periods heavier or lighter than in the past?	
		If yes, when did they change?	
		Do you have intermenstrual bleeding that occurs between your normal periods?	
		If yes, for how long has this occurred?	Months? Yrs?

Premenstrual Syndrome			
Yes	No		
		Do you have breast tenderness prior to your period?	
		If yes, how many days prior to your period does it begin?	Days?
		For how long has this occurred?	Months? Yrs?
		Do you have mood swings with your period?	
		If yes, how many days prior to your period does it begin?	Days?
		For how long has this occurred?	Months? Yrs?
		Do you have fluid retention prior to you period?	
		If yes, how many days prior to your period does it begin?	Days?
		For how long has this occurred?	Months? Yrs?
		Do you have weight gain prior to your period?	
		About how many pounds do you gain prior to your period?	Pounds?
		For how long has this occurred?	Months? Yrs?
		Do you crave sweets or bread products prior to your periods?	
		Do you develop headaches (not migraine) prior to your periods?	
		If yes, how many days prior to your period do they begin?	Days?
		For how long has this occurred?	Months? Yrs?
		Do you have menstrual cramps?	
		If yes, for how long?	Months? Yrs?
		Do you experience hot flashes?	For how long?
		Do you experience night sweats?	How many years?
		Have any of the above symptoms ever caused you to miss work or school, or cause you to be unable to carry out your daily responsibilities?	

Estrogen Dominance			
Yes	No		
		Do you have fibrocystic breast disease?	For how many months? Yrs?
		Have you ever had endometriosis	For how many months? Yrs?
		Do you have uterine fibroids?	For how many months? Yrs?
		Have you had ovarian cysts?	For how many months? Yrs?
		Which side?	Left? Right?
		Have you developed dark hair on your face?	How long ago did it begin? Months? Yrs?
		Have you developed dark hair on your breasts?	How long ago did it begin? Months? Yrs?
		Have you had a decrease in sexual desire?	For how many months? Yrs?
		Do you have painful intercourse?	For how many months? Yrs?
		Is pain due to vaginal dryness?	

Breasts			
Yes	No		
		Have you had a mammogram?	How many times?
		Date of last mammogram?	
		Was your last mammogram normal?	
		If no, then what were the findings?	
		Have you had abnormal discharge from your breasts?	
		If yes, what color?	For how many months? Yrs?
		Have you had a breast biopsy?	How many times?
		Have you had your breast(s) aspirated?	How many times?
		Do you have breast implants?	
		If yes, when was the surgery performed?	(mo/yr)
		Are they saline implants?	
		Are they silicone implants?	

Bone Density					
Yes	No				
		Have you had a bone density scan before?		If yes, give date:	
		Have you had an EKG performed in past 6 months?		If yes, give date:	
		Have you ever been diagnosed with osteoporosis?			
Recurrent Medications					
Yes	No				
		Do you currently take prescription medications? If yes, please list the medication, strength, times/day taken, and number of years taken.			
		Medication	Strength	Time per day taken	Number of years
Vitamins and Supplements					
Yes	No				
		Do you currently take vitamins and supplements? If so, please list each type, strength, times/day taken, and number of years taken:			
		Vitamin/Supplement	Strength	Times per day taken	Number of year