ADVANCED PAINCARE AND BIOHEALTH INSTITUTE

Women's Wellness Questionnaire

I. Patient Information			
Name:	DOB:	Age:	Gender:
Address:			
City:	State:	Zip:	
Phone:	Email:		

II. Goals
What are the top 3 symptoms/wellness goals you would like to address? 1. 2. 3.

III. History of Pregnancy	
How many pregnancies have you had?	How many children?
Any interrupted pregnancies? Yes □ No □	Have you had a hysterectomy? Yes □ Date_____No □
Have you ever used oral contraceptives? Yes □ No □	Have you had a tubal ligation? Yes □ Date_____No □
Currently using oral contraceptives? Yes □ No □	Have you had ovaries removed? Yes □ Date_____No □
If yes, any problems with contraceptives? Yes □ No □	

IV. Testing/Menstruation	
Check those that apply and note the date of the latest test:	
Mammogram: Yes □ Date_____No □ Results_____	PAP Smear Yes □ Date_____No □ Results_____
Last Period Date_____	How many days did it last?_____
Do you have or did you have PMS?_ Yes □ No □	
Since you first began having periods, have you ever had what you consider to be abnormal cycles? Yes □ No □	
If yes, explain (symptoms, age, etc.)	

V. Medical History		
Check all that apply	Personal History	Family member (s)
Fibrocystic Breast Disease	Yes □ No □	Yes □ No □
Breast Cancer	Yes □ No □	Yes □ No □
Uterine Cancer	Yes □ No □	Yes □ No □
Ovarian Cancer	Yes □ No □	Yes □ No □
Heart disease	Yes □ No □	Yes □ No □
Osteoporosis	Yes □ No □	Yes □ No □

*Services offered including wellness visits, not covered or billed to Insurance plans.

Thyroid disease	Yes □ No □	Yes □ No □
Blood Clots	Yes □ No □	Yes □ No □
Other Cancers	Yes □ No □	Yes □ No □

VI. OTC Medication/Supplements (include Aspirin, ibuprofen, antihistamines, sleep aids, laxatives, decongestants, vitamins, minerals, fish oils, protein powders, probiotics, etc.)			
Medication Name	Strength	Times per day	Start Date

VII. Lifestyle						
List use of:		Quantity	Daily	Weekly	Monthly	Occasionally
Tobacco	No □ Yes □	_____	□	□	□	□
Alcohol	No □ Yes □	_____	□	□	□	□
Caffeine	No □ Yes □	_____	□	□	□	□
Occupation_____		Level of Stress :	□Mild	□ Moderate	□ Severe	
Marital Status:						
Who lives in your household?						
Pets:						
Hobbies:						
Travel:						
Activity level/exercise:						
Exposure to radition:						
Other environmental exposures:						

VIII. Weight Concerns		
Lowest Weight:	Current weight:	Height:
When did you start gaining weight?		
Have you ever successfully lost weight? When? How		
Have you tracked food intake? Yes □ No □ Did you find it difficult? Yes □ No □ Are you willing to track? Yes □ No □		
Are you familiar with macronutrients? Yes □ No □	Do you exercise?	Yes □ No □
Are you happy with your current body weight? Yes □ No □	Do you eat out?	Yes □ No □
How many meals do you eat daily?	Do you skip meals ?	Yes □ No □
Have you had weight fluctuations of greater than 10 pounds due to dieting? Yes □ No □		
Please indicate if you tolerate the following foods: □Milk □Yogurt □ Cheese	Food cravings: □salty □ sweets □ fats □ Carbs □ Other:_____	
Indicate daily activity level beyond exercise_____		

_____ _____
Describe your typical diet and food choices:
Breakfast:
Lunch:
Dinner:
Snacks:
Caffeine: Carbonated beverages:

IX. Skin Health	
Have you had any Skin Lesions Removed? Yes □ No □	Do you wear sunscreen? Yes □ No □
Do you bruise easily Yes □ No □	Do you have dark spots on the face or arms? Yes □ No □
Any change in hair or nails? Yes □ No □	Any chronic rashes? Yes □ No □
Have you had laser treatments to your faces? Yes □ No □	Do you experience dryness or wrinkling of skin? Yes □ No □
Describe your skin care routine and cosmetic use:_____ _____ _____	

X. Report of Symptoms				
Symptom	Absent	Mild	Moderate	Severe
Stress	□	□	□	□
Weight gain	□	□	□	□
Weight loss	□	□	□	□
Heavy/irregular menses	□	□	□	□
Hot flashes	□	□	□	□
Dry skin/hair	□	□	□	□
Anxiety	□	□	□	□
Depression	□	□	□	□
Night Sweats	□	□	□	□
Vaginal dryness	□	□	□	□
Headaches	□	□	□	□
Irritability	□	□	□	□
Mood swings	□	□	□	□
Breast tenderness	□	□	□	□
Sleep disturbances/insomnia	□	□	□	□
Cramps	□	□	□	□
Fluid retention	□	□	□	□
Breakthrough bleeding	□	□	□	□
Fatigue	□	□	□	□
Loss of memory	□	□	□	□
Bladder symptoms	□	□	□	□

Arthritis	□	□	□	□
Difficulty climaxing	□	□	□	□
Decreased sex drive	□	□	□	□
Hair loss	□	□	□	□
Lack of energy	□	□	□	□
Bloating	□	□	□	□
Muscle pain	□	□	□	□
Constipation	□	□	□	□
Headaches	□	□	□	□
Skin rashes	□	□	□	□
Poor Concentration	□	□	□	□
Stiff muscles	□	□	□	□
Shortness of breath	□	□	□	□
	□	□	□	□

XI. Please describe any other information you feel it is important for us to know regarding your health