

FEMALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

2. List medications you are currently taking:

3. Any known drug allergies? _____

4. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

5. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

6. Date of last pelvic/gynecological exam: _____ Last Pap Test: _____ Last mammogram: _____

7. Last thermography? _____ Unusual results? _____

8. List significant non-GYN health issues (diabetes, surgeries, etc.):

_____**LIFESTYLE INDICATORS** < = less than > = greater than

Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day	or stopped recently	_____ (when?)
Coffee	None	<2 cups/day	>2 cups/day	or stopped recently	_____ (when?)
Soda	None	<2 cans/day	>2 cans/day	or stopped recently	_____ (when?)
Sweets/refined carbs		<twice/day	>twice/day	or stopped recently	_____ (when?)

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? (circle) Y N Amount _____

3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

5. How often do you exercise? never rarely sometimes regularly competitively

INSTRUCTIONS: Check either "Ongoing" or "Just w/ Period" for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity.

SIGNS & SYMPTOMS	SEVERITY			MORE INFORMATION
	ONGOING	JUST W/ PERIOD	MILD MODERATE SEVERE	
Mood swings				
Anxiety/Nervousness/Irritable (circle)				
Overly Reactive/Short fuse/Anger (circle)				
Low Mood/Depression (circle)				
Low Blood Sugar/High Blood Sugar				
Lowered self-esteem/self-image (circle)				
Care for others before yourself				
Sadness/Crying (circle)				
Trouble Concentrating				
Memory difficulties				
Fatigue/Anemia (circle)				
Increased Appetite/Constant hunger (circle)				
Sweet cravings/Carbs/Chocolate (circle)				
Caffeine/Stimulant cravings (circle)				
Salt cravings				
Headaches/Migraines (circle)				
Muscle Pain/Joint Aches/Backache (circle)				
Weight gain/Trouble Losing Weight (circle)				
Weight loss				
Water Retention				
Bloating/Belching/Gas (circle)				
Stomach Burning/Nausea/Indigestion (circle)				
Constipation				
Light colored stool				
Loose stool/Diarrhea/IBS (circle)				
Acne/Rashes/Brown Spots (circle)				
Excessive facial hair/body hair (circle)				
Body/Head hair loss (circle)				
Infertility				
Lowered libido/Heightened libido (circle)				
Hot flashes/Night Sweats (circle)				
Palpitations				
Breast tenderness/Breast cysts (circle)				
Nipple discharge				
Vaginal infections/Yeast Infections (circle)				
Urinary Frequency/Incontinence/Infections (circle)				
Dry eyes/Dry skin/Overall dryness (circle)				
Changes to Labia/Clitoral tissue (atrophy, thinning, discoloration, itching, burning) (circle)				
Vaginal changes (dryness, tearing, decreasing size) (circle)				

Any other symptoms? _____

REPRODUCTIVE HEALTH HISTORY (please fill in or circle the appropriate answer)

1. Age at onset of menarche (first period): _____ Approximate date of onset: _____
2. Are you currently using a method of birth control? Yes No
If yes, what method? _____
3. Are you, or have you used (please circle) oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception (aka "the day after" pill)? Yes No
When and for how long? _____
4. Are you, or have you used an IUD? Yes No If yes, when and for how long? _____
What type of IUD did you use? copper hormone other _____
5. Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)

6. Have you used, or are you currently using fertility or treatment? Yes No
If yes, please explain. _____
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, what hormone(s), dosage, & for how long? (Specify dates of use)

8. Have you been pregnant before? Yes No Age(s) of children: _____
Number of pregnancies? _____ Details/ Complications: _____
Number of live births: _____
Miscarriages: _____
Premature births: _____
Cesarean births: _____
Stillbirths: _____
Abortions: _____
Ectopic pregnancies _____
9. If you have had a miscarriage, how many weeks pregnant were you? _____
10. Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: _____
Treatment and/or Medication: _____
11. Have you had a vaginal infection? Yes No If yes, what? _____
Treatment and/or Medication: _____
12. Any history of... Ovarian cysts? Yes No Uterine fibroids? Yes No
Fibrocystic Breasts? Yes No Endometriosis? Yes No
Polycystic Ovarian Syndrome (PCOS)? Yes No Lichen Sclerosis? Yes No
Vulvodinia? Yes No

FOR CYCLING-AGE WOMEN (please fill in or circle the appropriate answer)

1. First day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes No When? _____
2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No
If yes, please give details. _____

3. How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)
<20 _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
4. How many days does menstruation typically last? _____
5. Is your cycle regular? Yes No Not Always Details: _____
6. Typical menstrual flow: Light Medium Heavy Details: _____
7. How many pads and/or tampons (circle) are used on heavy days? _____
8. Do you pass clots? Yes No How often? _____
9. Do you spot? Yes No At what point in your cycle? _____
10. Do you experience cramping? None Mild Moderate Severe
At what point in your cycle? _____
11. Do you experience abnormal vaginal discharge? Yes No If yes, when? _____
12. Do you experience vaginal itching and/or odor? Yes No If yes, when? _____
13. Do you experience breast tenderness? None Mild Moderate Severe
At what point in your cycle? _____ Change in breast size? Yes No
14. Do you experience nipple discharge? Yes No If yes, when? _____ Color? _____

FOR MENOPAUSAL WOMEN (please fill in or circle the appropriate answer)

1. Your age at the onset of menopause: _____ Year of onset: _____
2. Have you had a hysterectomy? complete (ovaries AND uterus) partial (uterus only)
3. Date of hysterectomy: _____ Reason for hysterectomy: _____

4. List any other GYN related surgeries: _____

5. Describe your experience transitioning into menopause (symptoms, strong emotions, thoughts, unusual stressors, etc.)

MENOPAUSAL WOMEN, CONT'D

6. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes No
 If yes, what were you prescribed? _____
 What dosage? _____ For how long? _____
7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Yes No
 If yes, what? _____
 What dosage? _____ For how long? _____
8. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No
 If yes, what? _____
 For how long? _____
9. Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No
 If yes, when? _____ Were you evaluate and/or treated by a GYN? Yes No
 Treatment: _____

PLEASE DESCRIBE YOUR CYCLE HISTORY.

10. How would you have described your menstruation?
 Easy Uncomfortable Difficult Debilitating
11. What was your typical menstrual flow? Light Medium Heavy
12. When you were cycling would you consider your cycle regular? Yes No
 If no, explain. _____
- Please describe any 'treatment' ever received for cycle issues. _____

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia
 How long has this been happening? _____
2. How many hours do you sleep a night on average? _____
3. Do night sweats wake you up? Yes No How often? _____
4. Do you wake up tired? Yes No How long has this been happening? _____
5. Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) Yes No
6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No



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NUTRITIONAL HEALTH HISTORY FORM

Please print clearly

PERSONAL INFORMATION

Name: _____ Sex: M F Date: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ E-Mail: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Marital Status (Circle): S M D Number of Children: _____

PERSONAL HEALTH HISTORY

List any major illnesses with approx. dates _____

List any surgery or operations with approx. dates _____

Past accidents, injuries or falls with approx. dates _____

Do you smoke? Yes / No If yes, how long? _____ How many per day? _____

To your knowledge, have you ever had long-term exposure to chemicals, pesticides, herbicides, radiation and/or chemotherapy, solvents or heavy metals? Yes/No

If yes, explain _____

Do you have, or have you ever had, "silver" fillings in your teeth? Yes/No

Do you have any Root canal(s)? Yes/No If yes, how many? _____

Have you had tooth extractions? Yes/No If yes, how many? _____

Are you currently having any trouble with your teeth?

If yes Please explain: _____

Do you or anyone in your family have Sickle Cell Anemia or Sickle Cell Trait? Yes/No

If yes, please explain: _____

WOMEN ONLY:

Date of last menstrual period _____ Age at first onset _____

Are your periods regular? Yes/No If not, explain: _____

Do you experience cramping? No Slight Moderate Severe

Do you experience clotting during your menstrual cycles? Yes / No

Do you have any PMS symptoms? Yes / No

If so, what kind? _____

Are you currently pregnant? Yes / No

Are you currently using birth control? Yes/No If yes, what kind? _____

Have you had a hysterectomy? Yes / No

If yes indicate complete or partial and year _____

Do you suffer from (circle all that applies) night sweats, hot flashes, memory loss

MEN ONLY:

Do you experience frequent urination? Yes / No If yes for how long _____

How many times do you get up at night to urinate? _____

Do you have strong urges to urinate with incomplete voiding Yes / No

What is your current energy level: Normal or Decreased If decreased, please explain:

_____ Do you experience cold hands or feet Yes/No? If yes, for how long? _____

Have you had any prostate related issue? Yes / No If yes, please explain and give date of last prostate exam _____

FAMILY HISTORY

Marital Status: S/M/W Name of spouse _____

Describe health of spouse _____

Number of Children, if any _____

Name of Parents/Siblings Age Sex Any physical conditions or concerns?

_____ M / F _____

_____ M / F _____

_____ M / F _____

_____ M / F _____

Any family history of serious illnesses? Cancer/ Diabetes/ Heart Disease/ Other _____

PRESENT COMPLAINTS

List the 4 main health complaints you have in order of their importance to you (List the problem you would most like to get rid of below as #1, the second "worst" problem as #2, etc.):

1. _____
First began how long ago? _____ How often does this bother you? _____
What treatments have you tried? _____

Has this problem been getting better, worse or staying the same? _____

2. _____
First began how long ago? _____ How often does this bother you? _____
What treatments have you tried? _____

Has this problem been getting better, worse or staying the same? _____

3. _____
First began how long ago? _____ How often does this bother you? _____
What treatments have you tried? _____

Has this problem been getting better, worse or staying the same? _____

4. _____
First began how long ago? _____ How often does this bother you? _____
What treatments have you tried? _____

Has this problem been getting better, worse or staying the same? _____

OTHER COMPLAINTS OR PROBLEMS: (use separate sheet if needed)

What is your present weight? _____ Are you ok with your weight? _____
What is your ideal weight? _____ What time of day are you most tired? _____

Do you get depression, anxiety, worry, lack of concentration or memory problems? If yes, please explain:

How many bowel movements do you currently have? Only indicate one of the following:

- _____ x per day
- _____ every other day
- _____ x per week

List any allergies or foods/substances you are sensitive to:

DRUGS, MEDICATIONS, SUPPLEMENTS

Current **medications/prescription drugs** being taken, including “over the counter” medications:

(use a separate sheet if needed):

Drug: _____ Taken For: _____ How Long? _____ How Often? _____

Drug: _____ Taken For: _____ How Long? _____ How Often? _____

Drug: _____ Taken For: _____ How Long? _____ How Often? _____

Drug: _____ Taken For: _____ How Long? _____ How Often? _____

Drug: _____ Taken For: _____ How Long? _____ How Often? _____

Drug: _____ Taken For: _____ How Long? _____ How Often? _____

Are you currently under the care of a physician or other health care professional(s)? No/Yes

If Yes, Doctor's name _____ Date of last visit _____

Any **nutritional supplements** (vitamins), herbs, tonics, homeopathic or other remedies you are taking _____

Please list any additional information you would like the doctor to be aware

of: _____

DIET AND LIFESTYLE:

HOW MUCH OF THE FOLLOWING DO YOU CONSUME PER WEEK?

If you used to do this, write “past”.

Coffee (sugar? milk?) _____ Tea (sweet/un-sweet?) _____

Alcohol _____ Chocolate _____

Cigarettes _____ Laxatives _____

Diet Soda _____ Regular Soda _____

Chicken _____ Lunch Meat (cold cuts) _____

Red Meat _____ Pork _____

Milk _____ Peanuts _____

Artificial sweeteners _____ Recreational Drugs _____

How much water do you drink per day? _____

Do you drink Juices? If so, what types: _____

What types of hobbies/activities do you enjoy? _____

MAJOR LIFE CHANGES: (example: divorce, job loss, relocation, trauma/accidents, etc.)

CURRENT DIET INFORMATION

Give some examples of *foods you eat currently*:

Breakfast _____

Lunch _____

Snacks _____

Dinner _____

Liquids _____

INFORMED CONSENT FOR NUTRITIONAL COUNSELING

I hereby request and consent to Nutritional Counseling and other diagnostic procedures, including Ionic Foot Detoxification, Saliva Testing, or Nutritional Blood Testing (drawing complete off site) or physical therapy, on me (or on the patient named below, for whom I am legally responsible) by Dr. Bianca Kiovanni and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic. I have had an opportunity to discuss with the doctor and/or with other office or clinic personnel the nature and purpose of nutritional counseling and other procedures. I understand that results are not guaranteed. I understand and am informed that, nutritional counseling is not intended to treat or cure any disease. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

Probability of risks occurring: The risks of complications due to nutritional counseling have been described as “rare.

Other treatment options, which could be considered, may include the following:

- **Over-the-counter analgesics and/or prescription medication.** The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- **Medical care,** typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- **Hospitalization** in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- **Surgery** in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows for a possible increase in severity and other degenerative changes. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult. I have read, or have had read to me, the above consent. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I have had the opportunity to discuss with the Doctor the nature and purpose of nutritional counseling and other procedures.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ **DATE:** _____

To be completed by patient’s Parent/Legal Guardian if the patient is under legal guardianship or minor

SIGNATURE OF PARENT/GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____

Office Financial Policy

325 Hammond Drive, Suite 201
Atlanta, GA 30328
(404)-256-0114

RESPONSIBILITY OF BILL

I, _____, (referred to hereafter as “the undersigned”) agree and understand that payment for any treatment/therapy/massage is due at the time of service, unless previous arrangements have been made. The undersigned hereby accepts full financial responsibility for charges and services rendered. I also agree that this obligation shall exist regardless of private contractual agreement between the undersigned and any insurance carrier, attorney, or third party not signing this agreement. Financial responsibility will also include charges for services not covered by insurance or for which payment is denied through any utilization review or pre-certification procedures. I also understand that if I suspend or terminate my care or treatment, the fees for services already rendered to me will be immediately due and payable. In the event of my payment default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required for collection. I understand that this policy applies if I am signing for a minor and/or dependent.

INSURANCE

If I have insurance all deductibles and co-payments are expected at the time of service or by an office approved, signed payment plan. (A "deductible" is a specific dollar amount that your health insurance company requires that you pay out-of-pocket each year before your health insurance plan begins to make payments to any doctor for your healthcare claims.) If I do not have health insurance, I understand payment is due at the time of service, or I have the option of creating an approved, affordable payment plan.

RETURN CHECK POLICY

Each check that is returned to the office for insufficient funds will automatically be subject to a \$25.00 return check fee. Future payments must be made in guaranteed funds (cash, money order, debit card) and checks may not be accepted for a minimum period of six months.

CANCELLED OR MISSED APPOINTMENTS

I understand that a \$20.00 fee may be assessed at the Doctor’s discretion for any prior scheduled appointment that I fail to attend without 24 hours advance notice to reschedule or cancel.

I have read or have had read to me, the above Office Financial Policy. I have also had the opportunity to ask any questions about its content, and by signing below I agree to this policy.

PATIENT NAME: _____ **DATE:** _____

To be completed by patient’s Parent/Legal Guardian if the patient is under legal guardianship or minor

SIGNATURE OF PARENT/GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____