BREAKTHROUGH MEDICINE

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FEMALE HEALTH HISTORY INTAKE

Last name: **First:** **Middle:**

Age: **Gender:** **Marital Status:** **Date of Birth:**

Reason for visit:

Last Medical Visit (date & with whom)

Please Check box if appropriate and note when it was performed.

☐ Thermal or Mammogram:	☐ Colonoscopy or Endoscopy:
☐ Bone Density:	☐ MRI/Cat Scan/Ultrasound/X-ray:
☐ General Blood Work:	☐ Dental Exam:
☐ Hormone Screen:	☐ Eye Exam:

Allergies Reactions (Medicine and Substance):

Please list: Dosage and Frequency of how you are taking Medications and Supplements

Medications (over the counter and prescribed)	Supplements (vitamins, amino, herbs….)

Family History: "F"= Father, "M"=Mother, "S"= Siblings, "GP"= Grandparents, "C"=Children

Allergy:	Cholesterol:	Brain Issues:	Prostate Issues:
Anemia:	Digestive Issues:	Mental Illness:	Thyroid Issues:
Asthma:	Diabetes:	Heart Attack:	Lung Issues:
Blood Pressure:	Female Issues:	Stroke:	Autoimmune:
Cancer:	Bone Loss:	Eye Issues:	Adrenal:

List all Surgeries & Hospitalizations, including date occurred:

Please note "D"= Disease, "I"= Immunized, "N"= Neither (also list most recent booster year)

Small Pox:	Rubella:	Chicken Pox:
Measles:	Tetanus:	Pertussis (whooping cough):
Mumps:	Diphtheria:	Haemophilus (HIB):
Hepatitis A:	Hepatitis B:	Polio:
Pneumococcal:	Meningococcal:	Influenza:
Rotavirus:	RSV:	Human Papillomavirus:

Please List All Reactions to Vaccinations:

List "Y"= Yes, "N"= No, "P"= Past regarding use of the following, if "yes", note amount and how often:

Antacids:	Steroids:	Antibiotics:
Analgesics:	Laxatives:	Enema:
Coffee:	Alcohol:	Soda:
Candy/Cookies:	Tobacco:	Recreational Drugs:

Present Height: Present Weight: Weight one year ago?

Max. weight? When? Min. weight? When? Ideal Weight:

Do you have good energy throughout the day? Explain:

Do you experience restful sleep? If you answered "No", please explain:

List last 10 years of type of work you have done:

Are you chemically sensitive to odors? If "YES", explain:

What are your hobbies?

Do you use pesticides, herbicides, or other chemicals around your home?

Exercise Routine (type and how often)

Past Medical History: Please Check Box

☐Arthritis	☐Emphysema	☐Cancer	☐Anxiety	☐Structural Injury	☐Kidney Disease
☐Allergies	☐Low Blood Pres.	☐Celiac	☐Depression	☐Hepatitis	☐Gallbladder Disease
☐Asthma	☐High Blood Pres.	☐Cohn's Disease	☐Diabetes	☐HIV / AIDS	☐Migraines
☐Alcoholism	☐Diverticulitis	☐GERD (heartburn)	☐Bipolar Disorder	☐Sinusitis	☐Thyroid Issues
☐Alzheimer's	☐Addiction	☐ Colitis	☐Insomnia	☐Gout	☐Parkinson's
☐Bronchitis	☐ Schizophrenia	☐Heart Murmur	☐Glaucoma	☐Lupus	☐Osteoporosis or Osteopenia
☐Chronic Fatigue	☐Eating Disorder	☐Heart Attack	☐Cataract	☐Multiple Sclerosis	☐Pneumonia
☐Cholesterol high	☐Epilepsy/Seizure	☐Angina	☐Concussion	☐Sojourns Syndrome	☐Tuberculosis
☐Hemorrhoids	☐Varicose Veins	☐Bladder Issues	☐Eczema	☐Psoriasis	☐Acne

Other, not listed:

Female History: Please note: "**P**" = "**Past**", "**C**" = "**Current**", "**N**" = "**Never**"

When was you last Female exam?

Period Irregular	Endometriosis	Ovarian Cyst	Uterine Cancer	Menopause
Heavy Period	Fibrocystic Breast	Vaginal Infection	Ovarian Cancer	Pregnancy #
Fibroids	PMS	Breast Cancer	Abnormal Pap	Birth #

HEALTH PROFILE

NAME **DATE**

Rate each of the following symptoms upon your typical health profile for:

Point Scale				
	0	***Never*** *or* ***Almost never*** *have the symptom*	3	***Frequently*** have it, effect is ***not severe***
	1	***Occasionally*** *have it, effect is* ***not severe***	4	***Frequently*** have it, effect is ***severe***
	2	***Occasionally*** *have it, effect is* ***severe***		

HEAD	____	*HEADACHES*
	____	*FAINTNESS*
	____	*DIZZINESS*
	____	*INSOMNIA*
	____	***TOTAL***
EYES	____	*WATERY OR ITCHY EYES*
	____	*SWOLLEN, REDDENED OR STICKY EYELIDS*
	____	*BAGS OR DARK CIRCLES UNDER EYES*
	____	*BLURRED OR TUNNEL VISION (Does not include near or far-sightedness)*
	____	***TOTAL***
EARS	____	*ITCHY EARS*
	____	*EARACHES, EAR INFECTIONS*
	____	*DRAINAGE FROM EAR*
	____	*RINGING IN EARS, HEARING LOSS*
	____	***TOTAL***
NOSE	____	*STUFFY NOSE*
	____	*SINUS PROBLEMS*
	____	*HAY FEVER*
	____	*SNEEZING ATTACKS*
	____	*EXCESSIVE MUCOUS FORMATION*
	____	***TOTAL***
MOUTH/ THROAT	____	*CHRONIC COUGHING*
	____	*GAGGING, FREQ. NEED TO CLEAR THROAT*
	____	*SORE THROAT, HOARSENESS, LOSS OF VOICE*
	____	*SWOLLEN OR DISCOLORED TONGUE, GUMS, LIPS*
	____	*CANKER SORES*
	____	***TOTAL***
SKIN	____	*ACNE*
	____	*HIVES, RASHES, DRY SKIN*
	____	*HAIR LOSS*
	____	*FLUSHING, HOT FLASHES*
	____	*EXCESSIVE SWEATING*
	____	***TOTAL***
HEART	____	*IRREGULAR OR SKIPPED HEART BEAT*
	____	*RAPID OR POUNDING HEARTBEAT*
	____	*CHEST PAIN*
	____	***TOTAL***
LUNGS	____	*CHEST CONGESTION*
	____	*ASTHMA, BRONCHITIS*
	____	*SHORTNESS OF BREATH*
	____	*DIFFICULTY BREATHING*
	____	***TOTAL***

GRAND TOTAL ____

DIGESTIVE TRACT	____	NAUSEA, VOMITING
	____	DIARRHEA
	____	CONSTIPATION
	____	BLOATED FEELING
	____	BELCHING, PASSING GAS
	____	HEARTBURN
	____	INTESTINAL / STOMACH PAIN
	____	**TOTAL**
JOINTS/ MUSCLES	____	PAIN OR ACHES IN JOINTS
	____	ARTHRITIS
	____	STIFFNESS OR LIMITATION OF MOVEMEMENT
	____	PAIN OR ACHES IN MUSCLES
	____	FEELING OF WEAKNESS OR TIREDNESS
	____	**TOTAL**
WEIGHT	____	BINGE EATING/DRINKING
	____	CRAVING CERTAIN FOODS
	____	EXCESSIVE WEIGHT
	____	COMPULSIVE EATING
	____	WATER RETENTION
	____	UNDERWEIGHT
	____	**TOTAL**
ENERGY/ ACTIVITY	____	FATIGUE, SLUGGISHNESS
	____	APATHY, LETHARGY
	____	HYPERACTIVITY
	____	RESTLESSNESS
	____	**TOTAL**
MIND	____	POOR MEMORY
	____	CONFUSION, POOR COMPREHENSION
	____	POOR CONCENTRATION
	____	POOR PHYSICAL COORDINATION
	____	DIFFICULTY IN MAKING DECISIONS
	____	STUTTERING OR STAMMERING
	____	SLURRED SPEECH
	____	LEARNING DISABILITIES
	____	**TOTAL**
EMOTIONS	____	MOOD SWINGS
	____	ANXIETY, FEAR, NERVOUSNESS
	____	ANGER, IRRITABILITY, AGRESSIVENESS
	____	DEPRESSION
	____	**TOTAL**
OTHER	____	FREQUENT ILLNESS
	____	FREQUENT OR URGENT URINATION
	____	GENITAL ITCH OR DISCHARGE
	____	**TOTAL**

FEMALE HORMONE SURVEY

NAME **DATE**

Please score: BLANK= No Symptoms. 1-5 (1=Mild 5=Severe)

Hot Flashes	_____
Night Sweats	_____
Irritability	_____
Mood Swings	_____
Weepy	_____
Irregular Periods	_____
Heavy Periods	_____
Bleeding between periods	_____
Low sex drive	_____
Lumpy breasts	_____
Unable to reach orgasm	_____
Painful intercourse	_____
Lack of vaginal lubrication	_____
Breast tenderness	_____
Drooping breasts	_____
Sleep problems	_____
Anxiety or panic attacks	_____
Depression	_____
Loss of motivation	_____
Feeling apathetic	_____
Fatigue	_____
Memory loss	_____
Thinning hair	_____
Dry skin	_____
Cellulite	_____
Decreased muscle strength	_____
Fluid retention	_____
Headache	_____
Joint pain	_____
Muscle pain	_____
Urinary incontinence	_____
Acne	_____
Facial hair growth	_____
Constipation	_____
Food Cravings	_____
Vaginal Discharge	_____
Vaginal Itching	_____

TOTAL _____