Optimal Health Center of Santa Rosa

HEALTH HISTORY for WOMEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD ——— HOT

- ❒ Cold hands or feet
- ❒ Chills
- ❒ Cold "in the bones"
- ❒ Areas of numbness

Thirst for cold / hot drinks
- ❒ Thirst, no desire to drink
- ❒ Absence of thirst
- ❒ Excessive thirst

- ❒ Night sweats
- ❒ Unusual sweats
  When_____ am / pm
  Where on body _____ _

- ❒ Hot hands, feet, chest
- ❒ Hot flashes
- ❒ Hot in afternoon
- ❒ Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY ——— OILY

- ❒ Dry skin
- ❒ Dry hair
- ❒ Dry eyes
- ❒ Dry brittle nails

- ❒ Dry mouth
- ❒ Dry lips
- ❒ Dry throat
- ❒ Dry nose / Nosebleeds

Where on your body?
- ❒ Edema / Swelling _____
- ❒ Rashes _____
- ❒ Itching _____
- ❒ Dandruff

- ❒ Oily skin
- ❒ Oily hair
- ❒ Pimples
- ❒ Weight gain / loss

DIGESTION

DIARRHEA ——— CONSTIPATION

BM: How often? _____x / every _____days
Stools keep shape? ❒ Y ❒ N
- ❒ Alternating diarrhea & constipation (IBS)
- ❒ Indigestion

- ❒ Gas
- ❒ Bloating
- ❒ Belching
- ❒ Poor appetite

- ❒ Nausea / Vomiting
- ❒ Bad breath
- ❒ Heartburn
- ❒ Excessive hunger

- ❒ Dry Stools
- ❒ Difficult to pass
- ❒ Tired after BM
- ❒ Foul smelling stools

ENERGY

LOW ——— HIGH

- ❒ Sudden energy drop
  Time of day: _____ am / pm
- ❒ Energy drop after eating
- ❒ Fatigue

- ❒ Dependence on caffeine / stimulants
- ❒ Wired / ungrounded feeling
- ❒ Body / Limbs feel heavy
- ❒ Body / Limbs feel weak

- ❒ Shortness of breath
- ❒ Heart Palpitations
- ❒ Blood pressure High / Low
- ❒ Bleed / Bruise easy

- ❒ Hard to concentrate
- ❒ Poor memory
- ❒ Dizziness / lightheaded
- ❒ Headaches _____x / week

SLEEP

Hours per night _____
- ❒ Difficulty falling asleep
- ❒ Wake ___x/ night @_____am / pm
- ❒ Wake to urinate: How often? _____
- ❒ Disturbing dreams
- ❒ Restless sleep
- ❒ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- ❒ Anger
- ❒ Irritability
- ❒ Anxiety
- ❒ Worry
- ❒ Obsessive thinking
- ❒ Sadness
- ❒ Grief
- ❒ Depression
- ❒ Joy
- ❒ Fear
- ❒ Timid / shy
- ❒ Indecision

EYES, EARS, NOSE, THROAT

- ❒ Poor vision
- ❒ Night blindness
- ❒ Red eyes
- ❒ Itchy eyes
- ❒ Spots in front of eyes
- ❒ Sinus congestion
- ❒ Phlegm (color_____)
- ❒ Poor hearing
- ❒ Ringing in ears
- ❒ Excess earwax
- ❒ Sore throat
- ❒ Dental problems
- ❒ Mouth sores
- ❒ Cough

MENSES

Age at first menses: _____
Length of full cycle: _____ days (i.e. 28)
Length of menses: ____ days (i.e. 3-4)
Last menses start date: ____ / ____
# of pregnancies: ____
# of births: _____ premature _____
# of abortions / miscarriages: _____

- ❒ Heavy periods
- ❒ Light periods
- ❒ Painful periods
- ❒ Irregular periods
- ❒ Changes in body/ psyche prior to menstruation (PMS)

- ❒ Cramps
  - ❒ Before bleeding
  - ❒ First day
  - ❒ During period
- ❒ Clots
- ❒ Breast tenderness

- ❒ Mood changes
- ❒ Fatigue w/ menses
- ❒ Digestive changes w/ menses
- ❒ Mid-cycle spotting
- ❒ Yeast infections
- ❒ Birth control pill (hormonal)

MENOPAUSE

Age at last menses: _____
Year changes began: _____

- ❒ Hot flashes _____x / day
- ❒ Night sweats _____x / week

- ❒ Vaginal dryness
- ❒ Loss of sex drive