Dr. Sara's Female Intake Form_2019

General Information

Best phone number to reach you at: * _____

Preferred method of contact : *
- ☐ Phone Call
- ☐ Text Message
- ☐ Email

How were you referred to Dr. Sara? *
- ☐ Patient Referral
- ☐ Yelp/Google
- ☐ Facebook/Website
- ☐ Insurance
- ☐ Friend or Family Member
- ☐ Others _____

If you were referred by a current patient of Dr. Frawley's please let us know by who so we can contact them to say thanks: _____

Home Address with street, house number, city and zip code * _____

_____

_____

_____

Health Insurance Provider * _____

Do you have a PPO or HMO policy *
- ☐ PPO
- ☐ HMO
- ☐ None

Insurance Policy number: * _____

Credit Card Number (only charged for drop ship supplements orders and/or late appointment cancellations or no shows) * _____

Credit Card Expiration Date (mm/yy) * _____

Credit Card CVV Code * _____

Billing Zip Code * _____

Marital status *
- ☐ Single
- ☐ Married
- ☐ In a relationship

Height : * _____

Weight : * _____

Occupation : * _____

Emergency Contact Name : * _____

Phone : * _____

Relationship : * _____

Medical History

Primary health care provider : * _____

Other healthcare providers: *

List your chief health concerns in the order of importance to you. Also include when they started. *

List any medical diagnosis you have received (i.e. diabetes, heart disease, depression, etc.) *

List any prescription medications you take including dosages and reason for taking them *

List any over counter medications or supplements you take and the reason for taking them *

Any known allergies to medications? * ☐ Yes ☐ No

If yes, specify them

Any known food or environmental allergies? * ☐ Yes ☐ No

If yes, specify them

Are any of your allergies life threatening? * ☐ Yes ☐ No

If yes, specify them _____

_____

_____

_____

Have you taken any antibiotics in the last year * ☐ Yes ☐ No

If yes, how many times? _____

Family History

Ages & Chronic Diseases of: _____

Mother: _____

_____

_____

_____

Father: _____

_____

_____

_____

Sibling(s): _____

_____

_____

_____

Grandparents: _____

_____

_____

_____

Aunts/Uncles: _____

_____

_____

_____

Symptoms

For the following symptoms list how often you experience them - often, sometimes, never or in the past.

General :

Sleep disturbance *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Fatigue *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Exposure to toxic chemicals *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Iron deficiency anemia *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Head

Headaches or migraines *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Difficulty concentrating *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Memory problems *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Head injury *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Ears, Eyes, Nose, Throat

Frequent colds *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Sinus congestion or infections *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Mouth sores *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Dental/gum infections *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Cracked lips *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Recent changes in vision *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Dry eyes *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Skin

Acne *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Eczema *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Dry skin *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Easy bruising/bleeding *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Skin rashes *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Digestion

Stomach pain and or/ cramps *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Acid reflux / heartburn *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Abdominal bloating or gas *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Nausea or vomiting *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Mental / Emotional

Mood swings or mood disorders *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Irritability *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Depression *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Anxiety/nervousness *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Cardiovascular

Heart disease *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
High blood pressure *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Heart palpitations *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Cold hands and feet *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Varicose veins *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Swelling of hands and feet *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Respiratory

Chronic Cough *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Asthma *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Shortness of breath *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Sleep apnea *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Neurological

Seizures *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Numbness and tingling *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Loss of balance *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Musculoskeletal

Joint pain or stiffness *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Neck/back pain *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Muscle weakness *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Muscle spasms or cramps *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Osteopenia/osteoporosis *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Urinary

Burning or pain during urination *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Frequent urination at night *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Inability to hold urine *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Bladder infections *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

Endocrine

Low libido *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Easy weight gain *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Hair loss *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Heat or cold intolerance *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Thyroid problems *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Blood sugar problems *	☐ Often ☐ Never	☐ Sometimes ☐ In the past

For Women :

Contraceptive Use * ☐ Yes ☐ No

If yes, what type _____

_____

_____

_____

Absent periods *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Heavy bleeding or spotting between cycles *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Cervical Dysplasia/ HPV *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Yeast Infections *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Endometriosis *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
PCOS *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
Uterine fibroids *	☐ Often ☐ Never	☐ Sometimes ☐ In the past
	☐ Often	☐ Sometimes

Difficult menopause - hot flashes, night sweat * ☐ Never ☐ In the past

Vaginal dryness * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Infertility * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

History of Miscarriage * ☐ Yes ☐ No

Recent changes in breasts * ☐ Yes ☐ No

Nipple discharge * ☐ Yes ☐ No

Date of last PAP exam * _____

History or abnormal PAP exam * ☐ Yes ☐ No

Lifestyle

How many alcoholic drinks per week? * ☐ None ☐ 0-2 ☐ 2-4 ☐ 4+ ☐ Others _____

Do you smoke? * ☐ Yes ☐ No ☐ In the past

Rate your current stress level(10 being the highest) * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What are the primary sources of your stress? * _____

_____

_____

_____

Do you have any dietary restrictions (religious, vegetarian, vegan, etc.)? * _____

Health Goals

What are your main health goals? * _____

_____

_____

_____

How motivated are you to reach your goals? * _____

How willing are you to change your eating habits to reach your goal? * ☐ Strongly willing ☐ Moderately willing ☐ Not willing ☐ Cannot say

What is your timeframe for reaching your goal? * _____