Willowbrook Health Center
4 Willowbrook Rd
Cromwell, Connecticut, US - 06416

Dr. Sara's Female Intake Form_2022

General Information

Which pronouns do you prefer? ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs

Best phone number to reach you at: *

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

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 *

Insurance Group Number *

Insurance Policy number: *

Do you have a copay or a deductible? If yes, what is it? *

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

General :

Sleep disturbance * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

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

Exposure to toxic chemicals * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Iron deficiency anemia * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Head

Headaches or migraines * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Difficulty concentrating * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Memory problems * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Head injury * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Ears, Eyes, Nose, Throat

Frequent colds * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Sinus congestion or infections *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Mouth sores *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Dental/gum infections *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Dry eyes *	☐ Often ☐ In the past	☐ Sometimes	☐ Never

Skin

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

Digestion

Stomach pain and or/ cramps *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Acid reflux / heartburn *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Abdominal bloating or gas *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Nausea or vomiting *	☐ Often ☐ In the past	☐ Sometimes	☐ Never

Mental / Emotional

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

Cardiovascular

Heart disease *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
High blood pressure *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Heart palpitations *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Cold hands and feet *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Varicose veins *	☐ Many	☐ Some	☐ None
	☐ Removed		
Swelling of hands and feet *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Respiratory

Chronic Cough *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Asthma *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Shortness of breath *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Sleep apnea *	☐ No	☐ Mild	☐ Severe
	☐ In the past		

Neurological

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

Musculoskeletal

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

Muscle weakness *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Muscle spasms or cramps *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Osteopenia/osteoporosis *	☐ No ☐ In the past	☐ Mild	☐ Severe

Urinary

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

Endocrine

Low libido *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Easy weight gain *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Hair loss *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Thyroid problems *	☐ No	☐ Yes	☐ In the past
Blood sugar problems *	☐ Often ☐ In the past	☐ Sometimes	☐ Never

For Women :

Contraceptive Use *	☐ Yes ☐ No		
If yes, what type			
Absent periods *	☐ Yes	☐ No	☐ In the past
Heavy bleeding or spotting between cycles *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Cervical Dysplasia/ HPV *	☐ Yes	☐ No	☐ In the past

Yeast Infections * ☐ Often ☐ Sometimes ☐ Never ☐ In the past

Endometriosis * ☐ Yes ☐ No ☐ In the past

PCOS * ☐ Yes ☐ No ☐ In the past

Uterine fibroids * ☐ Yes ☐ No ☐ In the past

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

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

History of Miscarriage * ☐ 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+

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 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? * _____