Supplemental Questionnaire for Patients Who Want Nutritional and BHRT Programs

Name: ______________________ **Birth Date:** ____________ **Today's Date:** ____________

Family History

Has anyone in your family had:

Diabetes ☐ Yes ☐ No Relation ______________________
Thyroid Disease ☐ Yes ☐ No Relation ______________________
Breast or ovarian cancer ☐ Yes ☐ No Relation ______________________

Allergies ☐ None

☐ Lactose intolerance
☐ Peanut allergy

List Drug and Reaction

____
____
____

Others (food, bee stings, etc) ______________________
____

Medications now being taken ☐ None **(Please bring all medications to your appointment!)**

Medication Dosage Frequency

____
____
____

Supplements now being taken ☐ None **(Please bring all supplements to your appointment!)**

____
____
____
____
____
____

Miscellaneous

Do you wear seatbelts? ☐ Yes ☐ No
Are there any personal problems you'd like to discuss (e.g., family or marital problems, concerns about AIDS or other diseases, or preventive health issues)? ☐ Yes ☐ No
Are you on disability? ☐ Yes ☐ No
Is litigation pending regarding a medical problem? ☐ Yes ☐ No

Alcohol consumption

Has there been a period when you consumed more than you presently do? ☐ Yes ☐ No
Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No
Do people annoy you by criticizing your drinking? ☐ Yes ☐ No
Have you ever felt guilt about your drinking? ☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or reduce a hangover? ☐ Yes ☐ No

General

Are you frequently ill? ☐ Yes ☐ No
Are you having ☐ fever ☐ chills ☐ sweats ☐ Yes ☐ No
Recent weight - Have you ☐ lost ☐ gained ☐ Yes ☐ No
What's the most you've weighed? ________ When? ____________
Do you have a loss of appetite? ☐ Yes ☐ No
Do you have difficulty ☐ falling ☐ staying asleep? ☐ Yes ☐ No
Are you incapable of experiencing pleasure? ☐ Yes ☐ No
Do you suffer from complete exhaustion? ☐ Yes ☐ No
Have you ever been treated for an emotional illness? ☐ Yes ☐ No
Are you depressed? ☐ Yes ☐ No
Do you have feelings of worthlessness or guilt? ☐ Yes ☐ No
Do you have difficulty concentrating? ☐ Yes ☐ No
Do you have recurrent thoughts of death or suicide? ☐ Yes ☐ No
Are you considered a nervous person? ☐ Yes ☐ No

Skin and Hair

Have you had a ☐ skin rash ☐ itching? ☐ Yes ☐ No
Have you had ☐ lumps ☐ growths ☐ changing moles? ☐ Yes ☐ No
Have you had significant changes in ☐ hair ☐ nails? ☐ Yes ☐ No
Have you experienced skin reactions to the sun, other than sunburn? ☐ Yes ☐ No

Eyes

Have you had double vision ☐, blurry vision ☐, or blind spots ☐? ☐ Yes ☐ No
Do you wear glasses ☐ or contact lenses ☐? ☐ Yes ☐ No
Do you have glaucoma ☐ or cataracts ☐? ☐ Yes ☐ No
Have you had laser treatment ☐ or surgery ☐ on your eyes? ☐ Yes ☐ No
Have you had any eye injuries or infections? ☐ Yes ☐ No
When was your last eye checkup? ____________
When was your last glaucoma test? ____________

Ears

Do you have any current ear problems? ☐ Yes ☐ No
Are you hard of hearing? ☐ Yes ☐ No
Do you have ringing in the ears? ☐ Yes ☐ No
When was your last hearing test? ____________

Nose and Throat

Have you had sinus trouble? ☐ Yes ☐ No
Do you have hay fever? ☐ Yes ☐ No
Have you had hoarseness or change in voice? ☐ Yes ☐ No
Do you have significant alteration in taste and smell? ☐ Yes ☐ No
Do you have nasal polyps? ☐ Yes ☐ No
Any history of radiation therapy to the face or neck? ☐ Yes ☐ No
Any history of thyroid disease? ☐ Yes ☐ No

Heart

- When was your last electrocardiogram? ________ Abnormal? ☐ Yes ☐ No
- Do you have any heart problems? ☐ Yes ☐ No
- Do you have high blood pressure? ☐ Yes ☐ No
- Do you have an elevated cholesterol level? ☐ Yes ☐ No
- Have you ever suffered a heart attack? If yes, when? ________ ☐ Yes ☐ No
- Do you have any chest pain or discomfort? ☐ Yes ☐ No
- How many pillows do you sleep on? ☐ Yes ☐ No
- Are your ankles often definitely swollen? ☐ Yes ☐ No
- Are you bothered by thumping, racing or skipping of the heart? ☐ Yes ☐ No
- Have you ever been told you have a heart murmur? ☐ Yes ☐ No
- Have you ever had a blood clot or thrombophelebitis? ☐ Yes ☐ No

Chest

- When was your last chest x-ray? ________
- Was it abnormal? ☐ Yes ☐ No
- Have you had asthma or wheezing? ☐ Yes ☐ No
- Do you have shortness of breath ☐ at rest ☐ with exertion ☐ at night? ☐ Yes ☐ No
- Do you have a frequent cough? ☐ Yes ☐ No
- Have you ever coughed up blood? ☐ Yes ☐ No
- Have you been exposed to asbestos? ☐ Yes ☐ No

Gastrointestinal

- Do you have trouble swallowing? ☐ Yes ☐ No
- Do you regularly have heartburn? ☐ Yes ☐ No
- Are you troubled by nausea or vomiting? ☐ Yes ☐ No
- Do you have abdominal pain? ☐ Yes ☐ No
- Have you ever been diagnosed as having ☐ ulcer ☐ gallbladder disease? ☐ Yes ☐ No
- Have you had any liver problems? ☐ Yes ☐ No
- Have you had hepatitis or jaundice? ☐ Yes ☐ No
- Do you have ☐ diarrhea ☐ constipation? ☐ Yes ☐ No
- Do you use laxatives? If yes, what? ________ How often? ________ ☐ Yes ☐ No
- Do you have hemorrhoids or other rectal problems? ☐ Yes ☐ No
- Have you had black or bloody stools? ☐ Yes ☐ No
- When was your last sigmoidoscopic exam? ☐ Yes ☐ No
- Have you been diagnosed as having colon polyps? ☐ Yes ☐ No

Men

- Do you have a history of prostate trouble? ☐ Yes ☐ No
- Any difficult sustaining an erection? ☐ Yes ☐ No
- Any difficult ejaculating? ☐ Yes ☐ No

Genitourinary

- Have you been bothered by frequent urination? ☐ Yes ☐ No
- Do you wake to urinate at night? ☐ Yes ☐ No
- Are you having burning pain while urinating? ☐ Yes ☐ No
- Have you passed blood in your urine? ☐ Yes ☐ No
- Have you ever had a kidney or bladder infection? ☐ Yes ☐ No
- Have you ever had a kidney stone? ☐ Yes ☐ No
- Do you have trouble starting or stopping the urine? ☐ Yes ☐ No
- Do you sometimes lose control of your bladder? ☐ Yes ☐ No
- Have you ever had a venereal disease? If yes, what? ________ ☐ Yes ☐ No
- Are you having any sexual problems? ☐ Yes ☐ No

Bones and Joints

Do you have joint pain or stiffness? ☐ Yes ☐ No

Do your joints ever get ☐ red ☐ swollen? ☐ Yes ☐ No

Do you have back pain that limits your activities? ☐ Yes ☐ No

Do you have severe neck pain? ☐ Yes ☐ No

Have you ever had gout? ☐ Yes ☐ No

Do you have osteoporosis? ☐ Yes ☐ No

Have you had hepatitis or jaundice? ☐ Yes ☐ No

Do you have muscle ☐ weakness ☐ tenderness? ☐ Yes ☐ No

Do you get muscle cramps when ☐ walking ☐ at night? ☐ Yes ☐ No

Neurological

Are you having frequent or severe headaches? ☐ Yes ☐ No

Have you had fainting or loss of consciousness? ☐ Yes ☐ No

Have you ever had a seizure or convulsion? ☐ Yes ☐ No

Are you ever bothered by a spinning sensation or vertigo? ☐ Yes ☐ No

Do you have a balance problem? ☐ Yes ☐ No

Do you have periods of lightheadedness? ☐ Yes ☐ No

Do you have difficult walking? ☐ Yes ☐ No

Do you experience ☐ numbness ☐ tingling in your arms or legs? ☐ Yes ☐ No

General Habit Questions

Name: ______________________ **Birth Date:** __________ **Today's Date:** __________

Food and Drink

Check all the following habits that pertain to you now or in the recent past.

- ☐ Caffeine
- ☐ Alcohol
- ☐ Sodas
- ☐ Diet sodas
- ☐ Fruit juices
- ☐ Milk/Soymilk/Ricemilk
- ☐ Sweets/Desserts
- ☐ Artificial Sweeteners
- ☐ Diet Pills
- ☐ Antidepressants

On average, how many of each of the following beverages do you drink in a day? If not daily, in a typical week?

Regular coffee ________ Daily/Weekly
Decaf coffee ________ Daily/Weekly
Caffeinated hot tea ________ Daily/Weekly
Caffeinated iced tea ________ Daily/Weekly

Regular sodas ________ Daily/Weekly
Diet sodas ________ Daily/Weekly
Fruit juice ________ Daily/Weekly
Milk ________ Daily/Weekly
Milk Substitutes ________ Daily/Weekly

Alcoholic ________ Daily/Weekly
Mostly
☐ wine ☐ beer ☐ hard liquor

Would you consider yourself to have a problem with alcohol? ☐ Yes ☐ No

On average, how many sweets/desserts do you consume in a day? ________

How many items of articifial sweetener do you use daily? ________

If you are currently taking diet pills, what are you taking? ________________ Dosage ________ Frequency ________

Tobacco

Check all the following habits that pertain to you.

☐ Smoke cigarettes How many years? ________ # of packs daily ________ In the past? ________
☐ Smoke cigars How many a day? ________ In a week? ________
☐ Nicotine gum How long? ________
☐ Nicotine patches What kind? ________ How long? ________
☐ Chew tobacco How long? ________

Have you ever tried quitting and not been able to? ☐ Yes ☐ No

Stress Index

Would you consider yourself to be under a new acute stress or a constant chronic stress? ☐ Yes ☐ No
If yes, check the best description(s) of your current stress.

☐ Family ______________________________ New / Chronic
☐ Financial ______________________________ New / Chronic
☐ Work-related ______________________________ New / Chronic
☐ Personal ______________________________ New / Chronic
☐ Illness ______________________________ New / Chronic
☐ Travel ______________________________ New / Chronic

Do you feel you handle your stress well? ☐ Yes ☐ No
Do you wake in the middle of the night thinking about things that happened during the day? ☐ Yes ☐ No
Do you feel the stress you're under is within your control? ☐ Yes ☐ No
How many hours do you work in a day (including mothers taking care of children)? ________ How many days? ________
How many total hours do you work in a week? ________
How long do you commute to get to work? Hours ________ Minutes ________
Do you travel extensively for your work? ☐ Yes ☐ No
If the definition of stress is not having enough time to care for yourself (e.g., sleep, eating well, exercise), would you consider yourself a stressed person? ☐ Yes ☐ No

Stress Management

Check all the items below that pertain to what you do to help handle your daily stresses.

- ☐ Exercise
- ☐ Take baths/Jacuzzi
- ☐ Long walks/hikes
- ☐ Read
- ☐ Meditate/Yoga/other forms
- ☐ Take regular vacations
- ☐ Eat comfort food
- ☐ Talk with family/friends
- ☐ Watch TV/movies
- ☐ Sleep
- ☐ See a counselor
- ☐ Take medication
- ☐ Play with pets
- ☐ Get body work (massage, facial)
- ☐ Drink alcohol

Other?____

Exercise/Activity

Is your job ☐ active ☐ sedentary?

How many hours a day are you sitting down (including travel time)?__________

On average, how much time do you exercise each day?

- ☐ 0 min.
- ☐ 15 min.
- ☐ 30 min.
- ☐ 45 min.
- ☐ 1 hour
- ☐ 1 hour, 15min.
- ☐ 1 hour, 30 min.
- ☐ 1 hour, 45 min.
- ☐ 2 hours or more

Describe what you do for exercise/activity. (Include gardening/yard work and housework.)

____

____

____

Do you think you get enough exercise on a weekly basis? ☐ Yes ☐ No If not, why?

____

____

____

Diet History

Do you ever skip meals? ☐ Yes ☐ No

If yes, how many meals on average do you skip in a week? __________

Which of the following best describes your meal plans?

- ☐ High carbohydrate, low fat
- ☐ A balance of carbohydrates, fats, proteins, and vegetables
- ☐ Vegetarian/Vegan
- ☐ Mostly eating out and on the go
- ☐ Constantly dieting
- ☐ None of the above. Please describe: ________________________________

Have you ever been on a diet? ☐ Yes ☐ No

If yes, please list every diet, including diet pills, that you have been on. (Use back of page if needed.)

____

____

____

Are you happy about your current weight?

If not, why not? ____

____

Which of the following food or items do you crave?

______ Breads, pasta and other starches ______ Salt

______ Chocolate ______ Sweets/sugar ______ Alcohol

______ Other ____

Do you feel you eat enough vegetables in a day? ☐ Yes ☐ No

How many glasses of water do you drink in a day? ______________

Female Health History

Name: ______________________ **Birth Date:** ______________ **Today's Date:** ____________

1. What was your age at the time of your first period? ____________________

2. Were your periods every month? Yes No

3. Are they regular now? Yes No

4. What was the date of your last menstrual period? ____________________

5. Have you had your uterus removed? Yes No
   Ovaries removed? Yes No
   If yes, when? __________ Why? ____

6. Did you ever use birth control pills? Yes No
   For how long? ___________ Are you using them now? Yes No

7. Did you ever have any fertility problems? Yes No

8. Date of last mammogram? _____________ Was it normal? Yes No
   If abnormal, explain: ____
   ____

9. Other than noted above, have you ever had an abnormal mammogram? Yes No
   If yes, explain: ____
   ____

10. Do you get routine mammograms? Yes No
    If no, why not? ____

11. Date of last PAP smear: ________________ Normal? Yes No

12. Have you had a uterine ultrasound? Yes No

13. Have you had a bone mineral density study? Yes No
    If yes, when? _____________ Results? ____________________

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Female Health History (continued)

14. Do you have any history of D & C's? Yes No

    If yes, when and why? ______________________________

15. Are you experiencing any of the following now?

Night sweats/hot flashes	Yes	No
Heart palpitations	Yes	No
Anxiety	Yes	No
Changes in hair/skin	Yes	No
Depression	Yes	No
Sleep disturbances	Yes	No
Emotional lability	Yes	No
Vaginal dryness	Yes	No
Decreased libido	Yes	No
Frequent headaches	Yes	No
Memory or concentration problems	Yes	No

16. How many full-term pregnancies have you had? ______________

17. How many miscarriages have you had? __________

18. What was the weight of your heaviest baby? __________

19. What was your weight before and after each pregnancy? ______________________

20. Were you able to lose the weight after each pregnancy without dieting? Yes No

21. Did your periods resume normally after each pregnancy? Yes No