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1	Date:	

## **HEALTH HISTORY QUESTIONNAIRE**

## FUNCTIONAL WELLNESS & ACUPUNCTURE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record. Please bring this questionnaire along with any recent medical tests to your initial appointment.

Name (Last, First, M.I.):		_ M _	F DOB:
Marital status: ☐ Single ☐ Partnered ☐	☐ Married ☐ Separated	☐ Divorced ☐ Wid	owed
Address:			
Home Phone:		Cell Phone:	
Email:		☐ Yes it is ok t updates. Your e kept private.	
Guardian & Phone (if under 18):			
Height:	Weight:	The second secon	Blood Type:
Occupation:		Employer:	
Employer Address:			
Emergency Contact:		Relationship:	•
Emergency Contact Cell Phone:		Emergency Contact	Other Phone:
How were you referred to FWC?			
Primary Care Physician:		Phone:	
Address:			
Prescription Medications Taken with Name	of Prescribing Physicia	n	
OTC Medications & Dietary Supplements Us	sed		
Other Health Care Providers Regularly See	n		
Name & Type	Phone Number		Reason For Visits
			:
		**************************************	
		194	
Major Health Issues to be Addressed in Ord	er of Significance		
Health Issue/Doctor Diagnosed			
	Severity	Description	
□ Y □ N	Severity	Description	
	Severity	Description	
□ Y □ N	Severity	Description	
□ Y □ N □ Y □ N	Severity	Description	
□ Y □ N □ Y □ N □ Y □ N	Severity	Description	

Further De	tails of Ma	ajor Health	Issues (Ho	w Long,	Past Treatme	ent Approaches, Hov	w Life is	Impacte	ed, W	hat M	lakes	Be	:tter/	/Wo	rse)
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Please List	All Allergi	ies to Medic	cations, Foo	ds or In	alants:								4.1		
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Please desc	cribe your	childhood	health:	Parrie			***************************************		•						
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Surgeries 8	Other Ho	spitalizatio	ons		-				1 177 Will 1- A						
Year	Reason	I W.B.T.A.			NIT WARREN .	P <sup>*</sup> ***********************************	The state of the s	Hospital					•		
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Water Control of the												·····•			
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Recent Med	lical Tests	T	el Free to A		ору)					**************************************					
Date		Test		Results										Delit 1 400	
According to the second	MINT NO. 1. 11 M. MINT M. M. MARCHAN							t nas ummanatanamian-							
No. 100 Personal Control of Contr									•	***************************************					
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Have you e	ver had a	blood trans	fusion?							· · · · · · · · · · · · · · · · · · ·		וב	Yes		No
				lad or Cı	rrently Have			The state of the s				4	163	1-	NO
□ Diabetes			☐ Allergies			☐ Glaucoma			ПΕ	mphys	ema	+			
☐ Heart Dise	ase		□ CVA (str	oke)		☐ Stomach Ulcers	· · · · · · · · · · · · · · · · · · ·		□В	eeding	Tend	len	cy		
☐ <b>As</b> thma		4	□ Pneumo	nia		☐ Constipation			ΠН	igh Blo	od Pr	ess	ure		
☐ Jaundice		en de marie de 17 et 1860 e - Marie Constante, e 1850 e 18 de de desir de l'activité d	☐ Arthritis	AND STATE OF THE CASE OF THE STATE OF THE ST	A American Commission of the C	☐ Diarrhea	The second contrast of		ΠМ	ultiple	Scierc	osis	;		
☐ STD(s)			☐ Measles			☐ Other GI Probler	ms		□м	ononu	cleosis	5			
☐ Meningitis			□ AIDS/HI	V		☐ Tuberculosis			□R	heuma	itic Fe	ver			
☐ Epilepsy			☐ Hepatitis	;		☐ Headaches/Migra	aines		ם ני	/me/Ti	ckborr	ne	Disea	se	
□ Paralysis			☐ Cancer			☐ Thyroid Disorder	rs		D A	utoimn	nune [	Dise	ease		
☐ Other (plea	ase list)														

		HEALTH	<b>HABITS</b>	AND P	<b>ERSONAL S</b>	AFETY
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	ALL QUESTIONS CO	ONTAINED IN THIS SEC	CTION ARE OF	PTIONAL AND WILL BE KEPT ST	RICT	TLY CO	ONF	DENTIA	<b>\L.</b>
Exercise	☐ Sedentary (No ex	(ercise)							
	☐ Mild exercise (i.e	., climb stairs, walk 3 b	olocks, golf)			CITTOR V COURT ROACESTER		**************************************	The state of the s
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)								
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)								
Diet	Briefly describe you	r diet and eating habits	5:	The state of the s				H-Pro-	
							***************	····	
		70° W. (# Laft)						and a supplement	- The second sec
		299-1-10					PT-1011 1004.	THE STATE OF THE S	
				The state of the s					7 (180.00 )
Caffeine	□ None	☐ Coffee	□ Tea			Cola			W-W-W-W-W-W-W-W-W-W-W-W-W-W-W-W-W-W-W-
	# of cups/cans per	# of cups/cans per day?						man-m-	
Alcohol	Do you drink alcoho	1?				Yes		No	
	How much & how o	ften?							
Tobacco	Do you use tobacco	?				Yes		No	:
The state of the s	How much & how o	ften?		The state of the s	nh mana				THE STATE OF THE S
Drugs	Do you currently us	e recreational or street	drugs?			Yes		No	
	How much & how o	ften?	Company Company and the Company of t		\$100 may 1 to \$10		4		!
Cortisone or	Have you ever taker	1?				Yes		No	
Prednisone	How much and for h	now long?	over minimum met großen met geseller des seller des seller des seller des seller des seller des seller des sel		.,,				:
Antibiotics	Have you had more	had more than 2 cours	ses in your life	etime?		Yes		No	
	Approximately how	many?							
Dental	Do you have silver a	malgam fillings?				Yes		No	
	Approximately how	many?	de consideration (1988). Hills describe andres	Me 444-Addensida		annander et e	V-1-0000000		
Birth History	Unusual (prolonged	labor, forceps delivery	, C-section)			Yes		No	
	Please Explain?						***************************************		
Environmental	Have you had any k	nown exposures to che	emicals, molds	, radiation, heavy metals etc.?		Yes		No	
Exposures	Please Explain?								
		The second section of the second seco		WOULD IN THE STATE OF THE STATE	•				
Sleep	Bed Time		Time Arise		# o	f Wak	e Up	S	
Computer & WiFi	Do you believe that	you are hypersensitive	to computers	or WiFi?	<b>□</b> \	es			□ No
Check Any of th		ations that You have	e Had						
☐ Tetanus		☐ Smallpox		☐ Diphtheria			Polic		
☐ Pertussis	L	3 Rubella		☐ Measles	·····			enza	
☐ Hepatitis B	200 L	] HPV	· ·	☐ Chickenpox/Shingles			Othe	er	
Which vaccinati	ons have you had i	n the past year?			~				
Where have you	traveled outside o	of the USA?		TOTAL CONTROL OF THE STATE OF T					

<b>FAMILY</b>	HEALTH	HISTOR	łΥ
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	LIVED TO	SIGNIFICANT HEALTH PROBLEMS		AGE/AGE LIVED TO	SIGNIFICANT HEALTH PRO	BLEMS
Father			Children	□ M □ F		
Mother		THE PROPERTY OF THE PROPERTY O		□ M		
	<u> </u>			□ F		
Sibling	□ F			□ M □ F		
	□ M			ΠМ		
	□ F			O.F.	The state of the s	
	ΟF		Grandmother  Maternal	The second secon		
	□ M □ F		Grandfather Maternal	370	The state of the s	
	□ M	The second secon	Grandmother			
	□ M		Paternal  Grandfather	, p , p , p , p , p , p , p , p , p , p		
Ol I- 76 A			Paternal			
	y of the Following	have Occurred in Your Blood Rel				
☐ Diabetes		☐ Allergies	☐ Kidney Disea	warnen wa	☐ Tuberculosis	
☐ Heart Disea	ase	☐ CVA (stroke)	☐ Stomach Ulce	ers	☐ Cancer	10 minutes and 10 min
□ Asthma		☐ Nervous System Ailment	☐ Alcoholism		☐ High Blood Pressure	
☐ Bleeding Te	endency	☐ Arthritis	□ Obesity		☐ Mental Illness	
		children, parents, partners, relatives,				
With whom do	o you live? (Include					
With whom do	o you live? (Include r been emotionally,	children, parents, partners, relatives,	friends, pets and thei			2 20 -
With whom do	o you live? (Include r been emotionally, r been treated for a	children, parents, partners, relatives, partners, relatives, physically or sexually abused?	friends, pets and thei			200
With whom do Have you ever Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional appetite or over eating?	friends, pets and thei	ir ages)		
With whom do Have you ever Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional	friends, pets and thei	ir ages)		
With whom do Have you ever Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional appetite or over eating?	friends, pets and thei	ir ages)		
With whom do Have you ever Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional appetite or over eating?	friends, pets and thei	ir ages)		
With whom do Have you ever Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional appetite or over eating?	friends, pets and thei	ir ages)		
With whom do Have you ever Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional appetite or over eating?	friends, pets and thei	ir ages)		
With whom do Have you ever Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional appetite or over eating?	friends, pets and thei	ir ages)		
With whom do	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused? nxiety, depression or other emotional appetite or over eating?	friends, pets and thei	ir ages)		
Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused?  nxiety, depression or other emotional appetite or over eating?  I experiences (divorce, death of a love	friends, pets and thei	ir ages)		
Have you ever	r been emotionally, r been treated for an	children, parents, partners, relatives, physically or sexually abused?  nxiety, depression or other emotional appetite or over eating?  I experiences (divorce, death of a love	friends, pets and thei	ir ages)		

			PATIENT SYMPTOMS		
Pa	in				
ļ	Describe where your pain is and check any c	of the	following that apply:		
_	Sharp	T	Din a		
	Cramping		Burning		THE PARTY I I AMERICAN THE PARTY OF THE PART
	Fixed		Dull  Better with Pressure		Moving
	Better with Cold		· MPPMIDA-A-Bankaran		Worse with Pressure
	Better with Heat		Worse with cold		Better with Heat
-	neral		Other		
Ge	ilerai				
	Head or Chest Cold		Often Thirsty		Chills
	Perspire Easily w/o Exertion		Anemia		Flu symptoms
	Fatigued Easily		Recent Weight Gain		Rarely Perspire
	Seldom Thirsty		Recent Weight Loss		Jaundice
	Night Sweats		Sudden Drop in Energy		Anxious
	Always Fatigued		Recurrent Fever		Depressed
He	ad, Ears, Nose, Mouth, Throat				
	Frequent Colds		Headache		Decreased Sense of Smell
	Sinus Congestion or Pain		Migraine Headache		Dry Mouth
	Facial Pain		Congestion in Ears		Excessive Saliva or Drooling
	Jaw tension, clicking, TMJ		Earache		Sores on Tongue
	Grinding Teeth		Tinnitus (Ear Ringing)	0	Sores in Mouth
	Frequent Dental Cavities		Difficulty Hearing		Sores on Lips
	Gum Issues		Deafness		Difficulty Swallowing
	Bleeding Gums		Nasal Congestion		Lump or Pit in Throat
	Dentures		Runny Nose		Sore Throat
	Dizziness, Vertigo, Loss of Balance	0	Nose Bleeds		Strep Throat
	Concussion		Sneezing	0	Swollen Lymph Nodes
	Seizures	a	allergies		Tonsillitis
Ey	95				
	Nearsighted	0	Sensitivity to Light		Watery Eyes
	Farsighted	0	Blurred Vision		Itchy Eyes
	Astigmatism		Floating Spots		Red Eyes
	Glaucoma		Pressure Behind Eyes		Conjunctivitis
	Cataracts		Eye Pain	0	Use Eyeglasses or Contacts
	Night Blindness		Dry Eyes		Blindness

Re	spiratory							
	Chronic Cough		Clear or White Phlegr	n		Shortness of Breath		
	Dry Cough		Yellowish Phlegm	APERFO A TESTINI I I I I I I I I I I I I I I I I I I		Emphysema		
	Tight, Rattling Cough		Blood Tinged Phlegm	***************************************	0	Wheezing		
	Loose Cough		Bronchitis			Asthma: more difficult exhale		
	Thick, Sticky Phlegm	□ Pneumonia				Asthma: more difficult inhale		
	☐ Thin, Watery Phlegm ☐ Pain with Deep B			n		Asthma: worse on exhale		
Ca	rdiovascular							
	High Blood Pressure		High Cholesterol or Ti	riglycerides		Swelling of Hands		
	Low Blood Pressure		Stroke			Swelling of Feet		
	Blackouts or Fainting		Blood Clot	PP1110 AMI (1) AA	0	Cold Hands		
	Arrhythmia (Irregular Heart Beat)		Phlebitis			Cold Feet		
	Heart Valve Issue, Murmur		Varicose Veins			Hot Hands or Palms		
	Tachycardia, Palpitations		Bruise Easily			Hot Feet or Soles		
	Angina or Chest Pain		Anemia			Generally too Hot		
	□ Coronary Artery Disease □ Edema				Generally too Cold			
Ga	Gastrointestinal							
	Constipation		Stomach Ulcers	9		Excessive Gas (Flatulence)		
	Diarrhea		Acid Reflux or GERD			Anal or Rectal Itching		
	Bloating within a few hours after meals		Greasy, floating Stool	s (Steatorrhea)		Excessive Appetite		
	Hard Stools Difficult to Pass		Phlebitis			Poor Appetite		
	Hemorrhoids		Indigestion			Bowel Movements Feel Incomplete		
	Frequent Laxative Use		Blood in the Stool			Urgent Bowel Movements		
	Diverticulosis/Diverticulitis		Upper Abdominal Pair	or Cramping		Fecal Incontinence		
	Inflammatory Bowel Disease (Crohn's, Ulcerative Colitis)	0	Lower Abdominal Pair	or Cramping		Hiatal Hernia		
	IBS (Inflammatory Bowel Syndrome)		Nausea			Parasites		
	Black Tarry Stool		Vomiting			Gurgling in Stomach		
	Frequent Belching	а	Mucus in the Stool			Bad Breath		
	How often do you have a bowel movement?							
	What is the consistency of your bowel mover	nent	s?					
Uri	nary and Genital	***************************************						
	Scanty Amount of Urine		Pain or Burning Urinat	ion		Frequent Urination		
	Flow does not Stop Quickly		Blood in Urine			Sores on the Genitals		
	Excessive Sexual Energy		Kidney Stones			Strong Smelling Urine		
	Low Sexual Energy		Pain During Intercours	se		Cloudy Urine		
	Urgency to Urinate		Inability to Achieve Or	gasm		Kidney or Bladder Infection		
	Profuse Amount of Urine		Pain in the Bladder Ar	ea		Dark Urine		
	How often do you urinate in 24 hours?			How often do you wake	e to	urinate at night?		

Rashes									
Hives	Skin and Hair		The state of the s						
Itching	□ Rashes	☐ Acne	AND THE PERSON OF THE PERSON O	☐ Moist Feet				************	
	☐ Hives	☐ Ulcerations or Sores	***************************************	☐ Moist Hands					
Psoriasis	□ Itching	☐ Moles		☐ Fungus on Skin					
Herpes Zoster (Shingles)	□ Eczema	☐ Recent Changes in Me	oles	☐ Fungus under Nails	S				
Bolis	□ Psoriasis	☐ Warts		☐ Weak or Brittle Nails					
Any numb areas? Any scars?  Steep Hyglene    If so, where?   If so, where?	☐ Herpes Zoster (Shingles)	□ Dry Skin		☐ Loss of Hair					
Any scars?    If so, where?	□ Boils	☐ Dry or Brittle Hair		□ Dandruff	***************************************				
Difficulty Falling Asleep (Wired)	Any numb areas?		If so, where?		ACRES COMMENTS AND ADMINISTRATION OF THE PARTY OF T			President 1	
□ Difficulty Falling Asleep (Wired) □ Sleep too Much □ Sleep with Electric Blanket or Waterbed □ Difficulty Staying Asleep □ Wake Up at Night Thinking □ Sleep with WiFi On □ Snoring □ Sheep in Afternoon □ Shallow Sleep □ Insufficient Sleep □ Need to Nap □ Difficulty Waking in Morning □ Wake Up at Night, Mind Empty, Eyes Open □ Steep Disturbed by Dreams □ Altered Sleeping Schedule (Shift Work) □ Nightmares □ Wake Up Unrefreshed □ Narcolepsy □ Normal Time Awake □ Narcolepsy □ Difficulty Waking in Morning □ Wake Up Unrefreshed □ Narcolepsy □ Normal Time Awake □ Difficulty Handling Stress/Openwhelmed □ Maric Episodes □ Sadness or Grief □ Suicidal Feelings □ Difficulty Handling Stress/Openwhelmed □ Narcolepsy □ Difficulty Handling Stress/Openwhelmed □ Difficulty Handling Stress/Openwhelmed □ Narcolepsy □ Difficulty Handling Stress/Openwhelmed □ Narcolepsy □ Difficulty Handling Stress/Openwhelmed □ Narcolepsy □ Difficulty Handling Stress/Openwhelmed □ Difficulty Handling Stress/Openwhelmed □ Narcolepsy □ Difficulty Handling Stress/Openwhelmed □ Difficulty Handlin	Any scars?	111 / 2 111 / 111	If so, where?			****			
□ Difficulty Staying Asleep □ Steep with WiFi On □ Snoring □ Snoring □ Snoring □ Need to Nap □ Need to Nap □ Wake Up at Night, Mind Empty, Eyes Open □ Nacy Up at Night, Mind Empty, Eyes Open □ Nacy Up at Night, Mind Empty, Eyes Open □ Nacy Up at Night, Mind Empty, Eyes Open □ Nacy Up at Night, Mind Empty, Eyes Open □ Nacy Up at Night, Mind Empty, Eyes Open □ Nacy Up at Night Up at Night, Mind Empty, Eyes Open □ Nacy Up at Night, Mind Empty, Eyes Open □ Normal Bed Time Normal Bed Time □ Depression □ Manic Episodes □ Sadness or Grief □ Manic Episodes □ Indecisiveness □ Indecisiveness □ Mood Swings □ Frequent Crying □ Mood Swings □ Frequent Anger or Irritation □ Tendency to Repress Emotions  WOMEN ONLY  **WOMEN ONLY**  **WOMEN ONLY**  **Period every days, Period lasts days  **Heavy periods, Irregulantly, spotting, pain, cramps, clots or discharge?  **Number of pregnancies Number of live births  **Are you pregnant or breastfeeding?  **Have you ladd a D&C, hysterectomy, cophorectomy, difficult delivery or Cesarean?  **Have you ever had an abnormal PAP or been diagnosed with endometriosis, uterine fibroids, ovarian cysts or pelvic  **Description**  **Description	Sleep Hygiene								
□ Difficulty Staying Asleep □ Snoring □ Snoring □ Snoring □ Snoring □ Need to Nap □ Need to Nap □ Might Mind Empty, Eyes Open □ Normal Seep Norman □ Normal Time Awake □ Normal T	Difficulty Falling Asleen (Wired)	□ Sleep too Much		Cloop with Electric Pla		d- 18/-			
□ Snoring □ Snoring □ Sleepy in Afternoon □ Shallow Sleep □ Insufficient Sleep □ Need to Nap □ Difficulty Waking in Morning □ Wake Up at Night, Mind Empty, Eyes Open □ Sleep Disturbed by Dreams □ Altered Sleeping Schedule (Shift Work) □ Nightmares □ Wake Up Unrefreshed □ Narcolepsy  Hours Slept per Night Normal Bed Time Normal Time Awake			nkina		II IKEL	OI Wa	erbe	za	
□ Insufficient Sleep □ Need to Nap □ Difficulty Waking in Morning □ Wake Up at Night, Mind Empty, Eyes Open □ Sleep Disturbed by Dreams □ Altered Sleeping Schedule (Shift Work) □ Nightmares □ Wake Up Unrefreshed □ Narcolepsy Hours Slept per Night Normal Bed Time Normal Time Awake    Normal Time Awake			HAIIIG			-			
Wake Up at Night, Mind Empty, Eyes Open	The state of the s		A-1			_			
Mightmares			raame						
Hours Slept per Night Normal Bed Time Normal Time Awake    Emotional								3)	
Emotional  Depression									
□ Depression □ Anxiety or Fear □ Difficulty Handling Stress/Overwhelmed □ Manic Episodes □ Sadness or Grief □ Suicidal Feelings □ Obsessions or Compulsions □ Indecisiveness □ Frequent Crying □ Obsessions or Compulsions □ Mood Swings □ Frequent Anger or Irritation □ Tendency to Repress Emotions □ WOMEN ONLY  Age at onset of menstruation:  Date of last menstruation:  Period every □ days; Period lasts □ days  Heavy periods, Irregularity, spotting, pain, cramps, clots or discharge? □ Yes □ New Only  Number of pregnancies □ Number of live births □ Yes □ New Yey ou pregnant or breastfeeding? □ Yes □ New Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey Yey Yey Yey Yey Ou pregnant or breastfeeding? □ Yes □ New Yey	Tiours stept per riight	Normal bed Time		Normal Time Awake		•	***************************************		
□ Manic Episodes □ Sadness or Grief □ Suicidal Feelings □ Indecisiveness □ Frequent Crying □ Obsessions or Compulsions □ Mood Swings □ Frequent Anger or Irritation □ Tendency to Repress Emotions    WOMEN ONLY	Emotional				TITELLITERITETTETTE M			***************************************	
□ Manic Episodes □ Sadness or Grief □ Suicidal Feelings □ Indecisiveness □ Frequent Crying □ Obsessions or Compulsions □ Mood Swings □ Frequent Anger or Irritation □ Tendency to Repress Emotions    WOMEN ONLY	□ Depression	□ Anxiety or Fear	WAA	□ Difficulty Handling Str	ecc/O	vonyh			
□ Indecisiveness □ Frequent Crying □ Obsessions or Compulsions □ Mood Swings □ Frequent Anger or Irritation □ Tendency to Repress Emotions  WOMEN ONLY  Age at onset of menstruation:  Period every days; Period lasts days  Heavy periods, irregularity, spotting, pain, cramps, clots or discharge? □ Yes □ Number of pregnancies Number of live births  Are you pregnant or breastfeeding? □ Yes □ Number of live births  Have you had a D&C, hysterectomy, oophorectomy, difficult delivery or Cesarean?  Please provide details: □ Yes □ Number of live births					C35/ U	VEI WI	CIIIIC	<b>5</b> U	
Mood Swings					leione	en e			
WOMEN ONLY  Age at onset of menstruation:  Date of last menstruation:  Period every days; Period lasts days  Heavy periods, irregularity, spotting, pain, cramps, clots or discharge?  Please provide details:  Number of pregnancies Number of live births  Are you pregnant or breastfeeding?  Have you had a D&C, hysterectomy, cophorectomy, difficult delivery or Cesarean?  Please provide details:  Have you ever had an abnormal PAP or been diagnosed with endometriosis, uterine fibroids, ovarian cysts or pelvic			itation						
Age at onset of menstruation:  Date of last menstruation:  Period every days; Period lasts days  Heavy periods, irregularity, spotting, pain, cramps, clots or discharge?				— Tendency to Repress	LITIOU	U113		***************************************	
Age at onset of menstruation:  Date of last menstruation:  Period every days; Period lasts days  Heavy periods, irregularity, spotting, pain, cramps, clots or discharge?  Please provide details:  Number of pregnancies Number of live births  Are you pregnant or breastfeeding?  Have you had a D&C, hysterectomy, oophorectomy, difficult delivery or Cesarean?  Please provide details:  Have you ever had an abnormal PAP or been diagnosed with endometriosis, uterine fibroids, ovarian cysts or pelvic		WOMEN	ONLY						
Date of last menstruation:  Period every days; Period lasts days  Heavy periods, irregularity, spotting, pain, cramps, clots or discharge?							************		
Period every days; Period lasts days  Heavy periods, irregularity, spotting, pain, cramps, clots or discharge?									
Heavy periods, irregularity, spotting, pain, cramps, clots or discharge?  Please provide details:  Number of pregnancies Number of live births  Are you pregnant or breastfeeding?  Have you had a D&C, hysterectomy, oophorectomy, difficult delivery or Cesarean?  Please provide details:  Have you ever had an abnormal PAP or been diagnosed with endometriosis, uterine fibroids, ovarian cysts or pelvic									
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Please provide details:			T	
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Do you currently or have you previously used birth control pills?	П	Yes		No
Are you currently pregnant?				No
Are you currently nursing?				No
Are you trying to become pregnant?				No
Do you suspect that you have fertility issues?		Yes	+	
Have you ever suffered a miscarriage?				No
Any urinary tract, bladder, or kidney infections within the last year?				No
Any blood in your urine?				No
Any problems with control of urination?		***************************************		No
	0	Yes		No
Any hot flashes or sweating at night?		Yes		No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?		Yes		No
Experienced any recent breast tenderness, lumps, or nipple discharge?		Yes		No
Date of last pap and rectal exam?		<u> </u>		
MEN ONLY	3	To a		
MEN ONLY				and the same
Do you usually get up to urinate during the night?		Yes		No
If yes, # of times		Ī	1	
Do you feel pain or burning with urination?		Yes		No
Any blood in your urine?		Yes		No
Do you feel burning discharge from penis?		Yes		No
Do you have problems starting the flow of urine or with dribbling urine?		Yes	0	No
Has the force of your urination decreased?		Yes		No
Have you had any kidney, bladder, or prostate infections within the last 12 months?		Yes		No
Do you have any problems emptying your bladder completely?		Yes		No
Any difficulty with erection or ejaculation?		Yes		No
Any testicle pain or swelling?		Yes		No
Date of last prostate and rectal exam?		Yes	_	No
Do you have a low sperm count?		Yes		No
	<u>i</u>		L	
The information provided in this Health History is true to the best of my knowledge.		d : <u></u>	•	
I understand and accept that I am responsible for full payment of my account and that payment is due at the time that service	is pro	/ided		
I also understand and accept that I am expected to notify FWA 24 hours prior to any cancellation of or changes to my appointment.			d that	if I
do not I am responsible for a \$50 cancellation fee.	-			·····
Claned		-		
Signed Date			-	
Parent/Guardian (if applicable)	1			