Adult Female Health History Form

Name: **Date of Birth:**

How did you hear about us? Or who referred you?

1. ALLERGIES (Add additional page if necessary)	
Allergen substance:	Reaction:

2. GOALS AND CONCERNS
What do you hope to achieve by coming to Healing Oceans?
Please list any special issues or questions you would like to have addressed: 1) 2) 3)
Please identify one specific goal or behavior you would like to work on over the next year.
When was the last time you felt well?
Did something trigger your change in health?
What makes you feel better?
What makes you feel worse?

3. HOME LIFE

Marital status: (please circle) **Single / Married / Divorced / Gay/Lesbian / Long term partnership**

List children, if any:	Child's name	Age	Gender

Others in household: Names: Employed?

Total number:

4. READINESS ASSESSMENT

Please rate on a scale of 1 to 5 how willing are you to improve your health using such things as the following:

Significantly modify my diet	**5**	**4**	**3**	**2**	**1**
Take several nutritional supplements per day	**5**	**4**	**3**	**2**	**1**
Modify my lifestyle (i.e. work demands, sleep habits)	**5**	**4**	**3**	**2**	**1**
Practice a relaxation technique	**5**	**4**	**3**	**2**	**1**
Have periodic labs to assess my progress	**5**	**4**	**3**	**2**	**1**
Engage in regular exercise	**5**	**4**	**3**	**2**	**1**

Comments:

5. CURRENT PROBLEMS (List in order of PRIORITY)

Describe Problem	Mild	Mod	Severe	**Prior Treatment / Approach**	**Success:**		
					Great	Good	Fair
Example: *Postnasal drip*		*X*		*Nasal steroids. Neti pot. Diet changes.*	*X*		

6. MEDICAL HISTORY						
Medical Diagnosis / Problems / Injuries	**New**	**Ongoing**	**Resolved**	**Date Started**	**Surgeries / Hospitalizations**	**Mo/yr:**

7-A. CURRENT MEDICATIONS AND NUTRITIONAL SUPPLEMENTS (ei. herbs, vitamins, homeopathy)			
Medication	**Dose**	**Frequency**	**Reason for use**

7-B. MEDICATION USE AND EFFECTS

Have your medications and supplements ever caused you unusual side effects? Describe:	**Yes**	**No**
Have you had prolonged or regular use of Motrin, Asprin, Tylenol, or NSAIDS (Advil, Aleve, etc.)	**Yes**	**No**
Have you had prolonged or regular use of acid blocking drugs? (Tagamet, Zantec, Prilosec, etc.?)	**Yes**	**No**
Frequent antibiotics? (Greater then 3x per year)	**Yes**	**No**
Ever on long term antibiotics? (Longer than 2 weeks at one time.)	**Yes**	**No**
Have you ever used steroids? (Prednisone, nasal allergy inhalers)	**Yes**	**No**
Have you ever used oral contraceptives or hormone replacement therapy?	**Yes**	**No**

8. DIET

How many caffeinated drinks do you have per day?	***0 1 2 3 4+***
How many servings of soda do you drink per day?	***0 1 2 3 4+***
Do you use artificial sweeteners?	**Yes No**
Ounces of water you drink in a day? *1 glass = 8 oz, 1 quart = 32 oz*	_____
How many meals do you eat out per week?	***0 1 2 3 4+***
How much food do you eat that is not *fresh* prepared at home?	_____% (approx.)
- List the main foods you eat not *fresh* prepared at home:	
Are you happy with your weight?	**Yes No**
If you are on a special diet, explain:	

For the past 24 hours, list foods, snacks, and beverages consumed:

Breakfast with beverages	Lunch with beverages	Dinner with beverages	Snacks	Other beverages

9. SLEEP

Average number of hours you sleep each night:

Do you have trouble falling asleep?	**Yes No**
Do you feel rested upon waking?	**Yes No**
Do you have problems with insomnia?	**Yes No**
Do you snore?	**Yes No**
Do you use sleeping aids?	**Yes No**

If yes, explain:

10. EXERCISE

Do you exercise regularly?	**Yes No**
If yes, how many times per week?	_____times for_____minutes
Type of exercise?	**Stretching Cardio/Aerobic Strength**
Rate your motivation for including exercise in your life:	Low Medium High

List any barriers that prevent you from exercising:

11. FAMILY HISTORY						
Simply check the box for any family members that have or had the following health problems						
	Father	**Mother**	**Brother**	**Sister**	**Grandparents**	**Children**
Age if alive						
-or at death						
Diabetes						
Glaucoma						
Colon cancer						
Breast/ovarian cancer						
Other cancer						
Heart attack						
Angina						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug abuse						
Depression						
Other mental illness						
Suicide						
Traumatic abuse						
Obesity						
Asthma						
Eczema / Psoriasis						
Food allergies						
Autoimmune disease						
Genetic disorders						
Thyroid						
Arthritis						
Digestive issues						
Other health issues						
Other health issues						

Do you have a family history of:

Heart attack in a sister or mother before the age of 65? **Yes No**

Heart attack in a brother or father before the age of 55? **Yes No**

12. SOCIAL HISTORY					
How well have things been going for you?	**Very well**	**Fine**	**Poorly**	**Doesn't apply**	**Comments**
Overall					
In school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your children					
With your parents					
With your partner					

Do you feel significantly less vital than you did a year ago?	**Yes**	**No**	**Unsure**
Are you happy?	**Yes**	**No**	**Unsure**
Do you feel your life has meaning and purpose?	**Yes**	**No**	**Unsure**
Do you like the work you do?	**Yes**	**No**	**Unsure**
Have you ever experienced a major loss in your life?	**Yes**	**No**	
Do you spend the majority of your time and money to fulfill responsibilities and duties?	**Yes**	**No**	
Would you describe your experience as a child in your family as happy and secure?	**Yes**	**No**	
Do you think you have an excessive amount of stress in your life?	**Yes**	**No**	
Do you feel you can easily handle the stress in your life?	**Yes**	**No**	
Do you believe stress is currently reducing the quality of your life?	**Yes**	**No**	

Daily stressors: Rate from 1 to 10. *(1 means little or no stress. 10 is the maximum)*

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Have you ever sought counseling?	**Yes**	**No**
Are you currently in therapy?	**Yes**	**No**
Do you practice meditation or relaxation techniques? How often?	**Yes**	**No**

Circle all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other_____

12. SOCIAL HISTORY (continued)

Have you ever been abused, a victim of a crime, or experienced a significant trauma? **Yes No Unsure**

Have you had any recent significant changes in your life? **Yes No**

Comments:

What are your resources for emotional support?

Spouse / Family / Friends / Religious or spiritual / Pets / Other_____

Over the past two weeks, how often have you been bothered by any of the following problems? (Just place a check in the box)	**0 Not at all**	**1 Several days**	**2 At least half of days**	**3 Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure, or that you have let yourself down or your family down				
Trouble concentrating on things, such as reading or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless recently that you have been moving around a lot more than usual				
Thinking you would be better off dead, or that you want to hurt yourself in some way				

13-A. RISK BEHAVIORS

Have you ever used tobacco products regularly? **Yes No**

	Yr. started	Amount day/week	Still use?
Cigars			**Yes No**
Cigarettes			**Yes No**
Other			**Yes No**

Describe any quit attempts:

Do you currently use other recreational drugs or substances that could affect your health? **Yes No**

Have you ever used IV drugs or inhaled recreational drugs? **Yes No**

Ever been exposed to any Toxic Substances, such as asbestos, DES, radiation, chemicals? **Yes No**

If yes or unsure, please explain:

13-B. RISK BEHAVIORS: ALCOHOL USE

Prior to current period, your alcohol intake was:	**Mild**	**Moderate**	**High**
Have you ever been told you should cut down you alcohol intake?		**Yes No**	
Do you get annoyed when people ask you about your drinking?		**Yes No**	
Do you ever feel guilty about your alcohol consumption?		**Yes No**	
Do you ever take an eye-opener?		**Yes No**	
Do you notice a tolerance to alcohol? (Can you "hold" more than others?)		**Yes No**	
Have you ever been unable to remember what you did during a drinking episode?		**Yes No**	
Have you ever been arrested or hospitalized because of drinking?		**Yes No**	
Have you ever thought about getting help to control or stop your drinking?		**Yes No**	
Do you get into arguments or physical fights when you have been drinking?		**Yes No**	

Circle the beverages you regularly consume and list the amount you drink PER DAY on average:

Beer	Zero	Less than 1	1	2	3	4	More than 4
Wine	Zero	Less than 1	1	2	3	4	More than 4
Hard liquor	Zero	Less than 1	1	2	3	4	More than 4
Other	Zero	Less than 1	1	2	3	4	More than 4

13-C. HIV/AIDS RISK

Certain activities and medical issues can increase your risk for becoming infected with the HIV/AIDS virus.

1. Sharing injection drug needles and syringes or "works".
2. Having sex without a condom with someone who *had* AIDS.
3. Having any sexually transmitted disease, like Chlamydia or gonorrhea.
4. Receiving a blood transfusion or a blood clotting factor between 1978 and 1985.
5. Having sex with someone who has done any of these things.

Have any of these activities or problems ever applied to you? **Yes No**

14. PREVENTIVE SCREENING

Check if done, with month & year if known:

Done	Test	Date
	Full physical exam	
	Bone density exam	
	Mammogram	
	Breast Thermography	
	Pap smear	
	Colonoscopy	

Do you:		**Use Helmet?**
Motorcycle?	**Yes No**	**Yes No**
Bicycle?	**Yes No**	**Yes No**
Ski or snowboard?	**Yes No**	**Yes No**
Skateboard?	**Yes No**	**Yes No**

Do you get regular dental check-ups? **Yes No**

Do you have a smoke detector at home? **Yes No** When was it last checked? _____

Do you always wear a seatbelt? **Yes No**

15. GYNECOLOGIC HISTORY

OBSTETRIC HISTORY: Write number on each line.

__ Pregnancies __ Vaginal births __ Caesarean births

__ Miscarriages __ Abortions __ Living children

Check any that apply:

__ Postpartum depression __ Toxemia/Eclampsia __ Gestational diabetes

__ Baby over 8 pounds __ Breast feeding → How long? _____

Please describe your level of satisfaction with your births:

MENSTRUAL HISTORY:

Age at first period: _____ How often do you get your period? _____

Last menstrual period: _____ How long do you bleed? _____

Pain during menses? **Yes No** Has your period ever skipped? **Yes No**

Currently use contraception? **Yes No** How long have you been on it? _____

(Please circle) **Condom / Diaphragm / IUD / Partner Vasectomy**
Birth Control Pills / Patch / NuvaRing

Are you in menopause? **Yes No Unsure** Age at menopause: _____

16. CURRENT SYMPTOMS (Please check only those you are currently experiencing)							
Yes	General Questions		Yes	Cardiovascular		Yes	Psychiatric
	Fever			Chest Pains			Depression
	Chills			Palpitations			Anxiety
	Sweats			Skipped beats			Memory loss
	Fatigue			Syncope / fainting			Suicidal thoughts
	Decreased appetite			Difficulty Breathing			Hallucinations
	Weakness			➔ on exertion			Paranoia
	Just don't feel well			➔ lying down			Phobia / fears of things
	Weight loss			Shortness of breath (night)			Confusion
	Sleep problems			Swelling in legs or ankles			Trouble concentrating
Yes	**Eyes**		**Yes**	**Gastrointestinal**		**Yes**	**Neurology**
	Blurred vision			Nausea			Paralysis
	Double vision			Vomiting			Unusual sensations
	Eye discharge			Diarrhea			Seizures
	Vision change or loss			Constipation			Tremors
	Eye pain			Change in bowel habits			Vertigo / dizziness
	Sensitivity to light			Abdominal pain			Frequent falls
				Black or tar-like stools			Frequent headaches
Yes	**Ears / Nose / Throat**			Bloody stools			Difficulty walking
	Earache			Gas / bloating			
	Ear discharge			Indigestion / heartburn		**Yes**	**Musculoskeletal**
	Tinnitus / ringing			Difficulty swallowing			Back pain
	Decreased hearing			Feel full early			Joint pain
	Nasal congestion			Pain w deep breath			Joint swelling
	Hoarseness						Muscle cramps
	Nosebleeds		**Yes**	**Endocrinology**			Muscle weakness
				Constantly cold			Stiffness
Yes	**Respiratory**			Constantly hot			Arthritis
	Cough			Constantly thirsty			Sciatica
	Difficult breathing at rest			Constantly hungry			Restless legs
	Excessive sputum			Unusual weight gain			Leg pain at night
	Wheezing		**Yes**	**Reproductive**			Dermatology
	Coughing up blood			Vaginal bleeding			
	Pain with deep breath			Missed periods			
				Heavy periods			
Yes	**Hematology**			PMS		**Yes**	**Urinary**
	Unusual bruising			Vaginal discharge			Incontinence / urine leak
	Unusual bleeding			Genital sores			Painful urination
	Swollen lymph nodes			Pelvic pain			Blood in the urine
				Infertility			Frequent urination
Yes	**Allergy**			Vaginal dryness			
	Hives			Hot flashes		**Yes**	Other?
	Frequent infections			Decreased libido			
	Itchy eyes			Painful intercourse			

16B. CURRENT SYMPTOMS (continued)

If you checked off any of the problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? *(Circle one)*

Not difficult **Somewhat difficult** **Very difficult** **Extremely difficult**

Because violence is so common in many people's lives, I ask all my patients about it.	
Have you ever been in an abusive relationship?	**Yes No**
Does your partner ever hit you, hurt you, or threaten you in any way?	**Yes No**
Are you ever frightened of your partner?	**Yes No**
Has anyone ever hit you, hurt you, or threatened you in the past?	**Yes No**

Organ Donation:
Do you want to be an Organ Donor? **Yes No Don't Know**
(Go to http://donatelifenj.org/instructions-for-registration)

Advanced Directives:
Do you have an advanced directive or a living will? **Yes No**
If you do, please forward a copy to us.

To the best of my knowledge, this is a complete and accurate statement of my health.

Signature: _____ Date: _____

Please bring this filled out form as well as any bottles of supplements or medications you may be on when you meet Dr. Ginsburg for the first time.

You will find much information about our practice at healing-oceans.com.

We please ask that you do not wear any perfume, cologne or any fragrances to the appointment. Thank you!!