MenoChat

Patient Health History Questionnaire

Patient Name (last, first, MI): _____

How did you hear of MenoChat? _____

Address _____

City _____ State _____ Zip Code _____

Home Phone #: _____ Cell Phone #: _____

Male or Female Marital Status _____

Email _____

Employer_____ Job Title _____

Emergency Contact: _____ Phone #: _____

Primary Care Provider: _____

Primary Care Provider Phone: _____

Preferred Pharmacy: _____

Pharmacy Phone: _____

History

Reason for Consultation: _____

_____

_____

Health Concerns/Symptoms: _____

_____

Desired Outcome: _____

_____

Are you currently under the care of a healthcare professional for a medical/health condition? _____

If yes, please describe: _____

_____

_____

Please check off any health conditions:

Condition	Past	Present	Never	Family History/relationship
Headaches				
Migraines				
Recurrent Sinus Infections				
Seasonal allergies				
Emotional Illness				
Depression				
Anxiety/stress				
Asthma				
Chronic Bronchitis				
Lung Problems				
Chronic Indigestion				
Stomach Ulcers				
Intestinal Disease				
Skin Problems				
Back Pain/Sciatica				
Herniated Discs				
Neck Pain				
Chronic Muscle/Joint Pain				
Carpal Tunnel Syndrome				
Fibromyalgia				
Diabetes				
Thyroid Disease				
Osteoporosis/ Osteopenia				
Heart Disease				
Chest Pain				
Irregular Heart Rate				
High Blood Pressure				
Low Blood Pressure				
Blood Clotting Problems				
Bleeding Disorder				
Stroke/Vascular Disease				
Constipation				

Diarrhea				
Liver Disease/ Hepatitis				
Kidney Disease				
Menstrual disorders				
Reproduction Problems				
Sexual/ Libido Problems				
Tendonitis				
Osteoarthritis				
Rheumatoid Arthritis				
Cancer				

List any additional health problems not listed: _____

List any disease/ condition in your family and the relationship not listed above: ____

Preventative tests, please list results (if known) and date:

Last cholesterol: _____

Bone density: _____

Colonoscopy: _____

Exercise stress Test: _____

List any surgeries/ operations: _____

Last menstrual cycle: _____

How many pregnancies _____ # of children ____ If any, # of miscarriages _____

Last Pap smear: _____ History of Abn Pap Smear? _____

Last mammogram: _____ History of Abn Mammo? _____

Have you ever had a hysterectomy? _____ If so for what reason? _____

Have you ever had your ovaries removed? ____ If so for what reason? _____

Describe any menstrual irregularities: _____

_____

Medications (may list more in separate paper if necessary): _____

_____

_____

_____

_____

_____

Supplements (vitamins, minerals, herbs, or homeopathic remedies): _____

_____

_____

Medication allergies: _____

Food/ Environmental allergies: _____

Special dietary habits: _____

_____

_____

What do you do for exercise? _____

How often do you exercise? _____

Smoking: _____ How many packs per day? _____ For how long? _____

Alcohol? _____ If so how often? _____ How much? _____

List hobbies/ sports/ recreational activities: _____

_____

_____

Please rate your sleep:

	None	Mild	Moderate	Severe
Difficulty falling asleep				
Difficulty staying asleep				
Dissatisfaction with sleep pattern				
Problems with daily functioning (fatigue, ability to functional at work/school, concentration, memory, mood)				

Thyroid Questionnaire

	Yes	No	Not sure
Do you have fatigue?			
Do you have elevated cholesterol?			
Do you have difficulty losing weight?			
Do you have cold hands/feet?			
Do you have foggy thinking?			
Are you sensitive to cold temperatures?			
Do you find it hard to concentrate on things?			
Do you have memory problems?			
Do you have depressed moods?			
Are you experiencing hair loss?			
Do you have less than one bowel movement a day?			
Do you have dry skin?			
Does your skin itch?			
Do you have fluid retention?			
Do you have recurrent headaches?			
Do you have restless sleep?			
Are you very tired when you wake?			
Do you have fatigue in the afternoon?			
Do you experience tingling or numbness in your hands or feet?			
Do you have decreased/ difficulty sweating?			
Any infertility or miscarriages?			
Do you have any recurrent type infections?			
Do you have joint pain?			
Do your muscles ache?			
Do you have thinning eyebrows or eyelashes?			
Is your tongue enlarged with teeth indentations?			
Is your skin pasty, puffy, or pale?			
Do you have decreased body hair?			

Is your voice hoarse?			
Do you have a slow pulse?			
Do you have low blood pressure?			
Does your body temperature run below the normal 98.6?			
Do you have sleep apnea?			

GI Questionnaire

	Yes	No	Not Sure
Malgestion: Do you have foul smelling stools?			
Do you eat fast, or not take the time to eat slowly?			
Do you eat standing up or in a rush?			
Do you have skin problems such as eczema or psoriasis?			
Hypochlorhydria Problems: Do you have problems belching after eating?			
Do you have burning or flatulence within an hour of eating?			
Do you have skin rashes, acne or anal itching?			
Do you have peeling, cracking fingernails?			
Do you have food sensitivities or allergies?			
Intestinal Permeability Problems: Do you have an autoimmune disease (e.g. Lupus, hypothyroidism, rheumatoid arthritis?)			
Do you feel you probably eat poorly?			
Do you have a lot of stress in your life?			

Hormonal Imbalance (please mark which of the following symptoms are troublesome)

	Yes	No
Hot flashes		
Heart palpitations		
Heavy menses		
Fibrocystic breasts		
Thinning skin		
Mood swings (PMS)		
Cystic ovaries		

Foggy thinking		
Irritability		
Uterine fibroids		
Urinary incontinence		
Vaginal dryness		
Weight gain		
Increased body/facial hair		
Night sweats		
Acne		
Depressed mood		
Headaches		
Bone loss		

I have reviewed the Notice of Privacy Practices. _____ Yes _____ No

The privacy of your protected health information is utmost importance to MenoChat. As such we wish to contact you in the most efficient and effective manner as possible. Please help us be completing the information below:

Preferred method to reach you? Home phone _____ Cell phone _____ Email _____

Who can we leave a message with?

Only me _____ On my machine/Voicemail _____ other _____

Any other remarks? _____

_____

_____

Patient Signature: _____ Date: _____

(can be replaced by name if filing electronically)