APEX ADVANCED HEALTH SOLUTIONS

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HEALTH & LIFESTYLE

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Female Extensive Medical and Health Survey

Name:		Age:	Sex:	Marital status: M S D W	Birth date:	
Address:		City:		St:	Zip:	
Phones: Home	Work:	Fax:		Cell:		
Occupation:		Past occupations:				
Name of spouse/partner:		Age:	Occupation:			
Best days & times to reach you:		E-mail:				
How did you hear about us?			Travel time to office:			
Credit Card info, if indicated: Card holder name:			Credit Card type: MC VISA DIS			
Credit Card #:		Exp. date:	V-Code (3 digits on back of card):			
Credit Card billing address:						

PLEASE DESCRIBE YOUR MAJOR PROBLEMS AND/OR SYMPTOMS. If none, please write your reason for seeking this consultation. Please be clear and concise to help us help you. Include when the symptoms first appeared. Write what you can in the space provided. If you need more space add a separate sheet of paper.

If you have seen other physicians for these problems, indicate the results of these evaluations:

List your short-term goals for coming to this office:

List your long-term goals:

Height:	Weight:	Lowest adult wt:	Highest adult wt:	Desired wt:
Last Dr. visit:	Blood pressure:	Heart rate:	Allergies/sensitivities list:	

Smoke	Y N	Year started:	Packs per day:	Year stopped:
Alcohol	Y N	Year started:	How much:	Year stopped:
Street drugs	Y N	Type:	How often:	Year stopped:
Caffeine	Y N	Type:	How much:	How much:
Sleep problems	Y N	Type:	Type:	Type:
Exercise	Y N	Type:	How Often:	How often:
Cosmetics Y N	Perfumes Y N	Aftershaves Y N	Scented soaps Y N	

Do you have now or have you ever had any problems with any of the following?

1	HEAD, NECK	Y N	13	UTERUS, VAGINA	Y N
2	EYES, VISION	Y N	14	BACK, SHOULDER BLADES	Y N
3	EARS, HEARING	Y N	15	RIBS, HIPS	Y N
4	TEETH	Y N	16	ARMS, LEGS	Y N
5	NOSE, MOUTH, VOICE	Y N	17	NERVE, BRAIN DISEASE	Y N
6	LUNGS, BREAST, CHEST	Y N	18	SEIZURE, MIGRAINES	Y N
7	HEART	Y N	19	SKIN PROBLEMS	Y N
8	ARTERIES, VEINS	Y N	20	BLOOD DISEASES, SPLEEN	Y N
9	STOMACH, GALLBLADDER	Y N	21	GLANDS, OBESITY	Y N
10	LIVER, PANCREAS	Y N	22	CANCER	Y N
11	BOWELS, RECTUM, HERNIA	Y N	23	PSYCHIATRIC PROBLEMS	Y N
12	KIDNEY, BLADDER	Y N	24	PREGNANT	Y N
			25	OTHER CONDITIONS	Y N

Explain Any "Yes" Answers:

Major Hospitalizations-List:

Heart Disease Risk Factors

Y N	Age Years - Male ≥ 45 Female ≥ 55 or early menopause without estrogen replacement therapy
Y N	Family history of premature Heart Disease (definite myocardial infarction or sudden death before 55 in father / close male relative, or 65 in mother / close female relative)
Y N	Current cigarette smoker
Y N	Hypertension (Blood pressure ≥ 140/90 mm Hg confirmed by measurements on several occasions or taking antihypertensive medication
Y N	Low HDL (good) cholesterol (<35 mg/dl confirmed by measurements on several occasions [0.9 mmo/L]
Y N	Diabetes mellitus (sugar)
Y N	High HDL (good) cholesterol (≥ 60 mg/dl [1.6 mmo/L]

Your Tests, Specify if known:		Last Physical:	Xrays:	GI Series:
Gall bladder:	Kidney:	EKG:	Stress EKG:	Angiogram:
Ultrasound:	Blood Tests:	Others:		

Name: _____

Name: _____

Have you ever been on prolonged antibiotic therapy: Y N If Yes, what & why:

Have you traveled out of the country? Y N If yes, where & when?

Have you been treated for parasites? Y N Have you been tested for parasites? Y N

Do you do any stress reduction/relaxation such as meditation, yoga, self-hypnosis, etc.? Y N

What:	How Often:	Length of Sessions:	
Your stress level: Low Moderate High			
Sleeping Habits:	Hours/Night:	Restless or Restful	What Time You Retire:
	Wake During Night: Y N	Dream: Y N	

What are your hobbies or interests?

Immunizations, if Known:

Smallpox:	Polio:	Mumps:	Pneumonia:	Pertussis:
Tetanus:	Flu:	Measles:	Diphtheria:	Other:

Did your mother have any problems during her pregnancy with you (illness, stress, smoking, meds, alcohol)? Y N

Were you bottle or breast fed? Was your home life (circle): loving supportive stressful abusive peaceful

loud argumentative educational alcoholic friendly single-parent lonely or other—list

Childhood Illnesses (circle): colic eczema asthma polio allergies bronchitis pneumonia meningitis rheumatic fever recurrent colds

ear infections thrush German measles bedwetting tonsils out persistent diaper rash learning problems hyperactive or others—list

Family History	Living	Age	Health Problems**, Mental Illnesses or Cause of Death
Father	Y N		
Mother	Y N		
Brothers/Sisters	#		
Children	#		

** Cancer, Thyroid, Hypertension, Heart Disease, Stroke, Diabetes, Aortic Aneurysm, Asthma

Other household members now living with you. Include family members, non-family members and pets.

Name	Relationship	Age	Occupation

Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify

Alcoholism	Allergies
Arthritis	Asthma
Cancer	Epilepsy
Colitis/Crohn's Ds.	Diabetes
Herpes	Shingles
Drug Problems	Eczema
Heart Disease	High Blood Pressure

Please indicate if you or any family members or grandparents, ever had any of the following problems—Specify

Hepatitis	Frequent Infections
High Cholesterol	Bleeding/Bruising
Anemia	Low Blood Sugar
Digestive Disease	Weight Problems
Psoriasis	Urinary infections
Lupus	Mental Illness
Migranes	Pneumonia
Polio	Prostate Problems
Rheumatic Fever	Rheumatoid Disease
Sinus Disease	Strokes
Thyroid Problems	Tuberculosis
Ulcers	Venereal Disease
Comments/Explanations	

Read carefully through the list of symptoms in each group, and put a check mark next to each symptom that you have. (If you check off the same symptom in more than one group, that's fine.)

SYMPTOM GROUP 1		Memory problems		Mood swings		Excessive Hair		Unstable blood sugar	
PMS		Lethargic depression		Foggy Thinking		Polycystic ovaries		Thin and/or dry skin	
Painful +/or lumpy breasts		Night sweats		Gallbladder problems		Unstable blood sugar		Foggy thinking	
Cyclical headaches		Bladder infections		Weight gain		Infertility		Brown spots on face	
Insomnia		Painful intercourse		Migranes		Thinning hair on head		***Total Checked***	
Weight gain		Hot flashes		Insomnia		Ovarian cysts			
Infertility		***Total Checked***				Brown spots on face			
Early miscarriage		**SYMPTOM GROUP 3**		***Total Checked***		***Total Checked***			
Anxiety		Puffiness/Bloating		**SYMPTOM GROUP 4**		**SYMPTOM GROUP 6**			
Total Checked		Heavy bleeding		***Total of Grps 1 & 3***		Debilitating fatigue			
SYMPTOM GROUP 2		Anxious depression		**SYMPTOM GROUP 5**		Low blood pressure			
Vaginal dryness		Breast Tender		Acne		Intolerance to exercise			

Date of last pap smear: Was it normal? Y N If no, explain:

Have you ever had an abnormal pap smear? Y N What was found? How treated?

Date of last mammogram? Was it normal? Y N If no, explain:

Date last stools checked for blood: Was it normal? Y N If no, explain:

Date of last sigmoidoscopy or colonoscopy? Was it normal? Y N If no, explain:

Do you do breast self exams? Y N How often?

Pregnancies—Number: Dates/Outcomes:

Have you breast fed? Y N When & how long?

Do you use birth control? Y N What methods & how long?

Are you in menopause? Y N Do you still spot or bleed? Y N Describe:

Are you post-menopausal? Y N If yes, when did you go through menopause?

Name: _____

Name: _____

Please discuss any gynecological complaints:

1	Breast lumps	Y N		12	Pain with intercourse	Y N
2	Fibrocystic breast disease	Y N		13	Change in sex drive or pleasure	Y N
3	Nipple discharge	Y N		14	Frequent urination	Y N
4	Breast Operations	Y N		15	Bladder infections	Y N
5	Pelvic Inflammatory disease	Y N		16	Genital herpes	Y N
6	Endometriosis	Y N		17	Venereal warts	Y N
7	Fibroids	Y N		18	Vaginal yeast infections	Y N
8	Ovarian cysts	Y N		19	Any venereal disease	Y N
9	Fertility problems	Y N		20	Vaginal itching or burning	Y N
10	Lower abdominal pain	Y N		21	Undiagnosed vaginal discharge	Y N
11	Pressure in vagina	Y N				

Explain Any "Yes" Answers:

Menstrual Cycle Symptoms		P—Prior D—During A—After
1	Intermittent cramps	P D A
2	Constant cramps	P D A
3	Low back pain	P D A
4	Pressure sensations	P D A
5	Headaches	P D A
6	Sugar cravings	P D A
7	Depression	P D A
8	Irritability	P D A
9	Breast Tender	P D A
10	Acne	P D A
11	Mood swings	P D A
How severe are the symptoms?		
What treatments have you tried?		

Menstrual Cycle Information
Your age at your first period:
Dates of last 2 periods: 1: 2:
Length of cycles: Is it irregular? Y N How?
Do you spot in between? Y N How many days of bleeding?
Number of pads or tampons: Type of pad or tampon:
Do you pass clots? Y N Do you use hygiene products? Y N
Type of underwear?

Living Environment—circle: Urban Suburban Country Seaside Lakeside

Type of Heat: Humidifier: Y N Wood Stove: Y N Type of Insulation:

Is the Cellar: Dry Damp Musty Dusty Is the House: Old New Has it been treated for pests? Y N What Kind?

Do you use feather or down covers, comforters or jackets? Y N Do you have an air filter or cleaner? Y N

Are there animals at home or places you visit frequently? Y N What kind:

Do you use strong chemical cleaners, solvents, paints, etc.? Y N What?

Fill in "C" for current problem; "I" for an intermittent problem; "P" for a past problem

____ Headaches	____ High blood pressure	____ Weakness
____ Neck lumps or swelling	____ Skipped heartbeats	____ Painful feet
____ Loss of balance	____ Racing heart	____ Leg cramps
____ Dizzy spells	____ Chest pain or pressure	____ Trembling or tremors
____ Vertigo	____ Swollen feet or ankles	____ Seizures or epilepsy
____ Blackouts or fainting	____ Difficulty breathing at night	____ Numbness or tingling
____ Blurry vision	____ Varicose veins or phlebitis	____ Skin tumors
____ Double vision	____ Recurring indigestion	____ Dry skin
____ Cataracts	____ Nausea or vomiting	____ Acne
____ Eye pain or itching	____ Intestinal gas/ flatulence	____ Eczema
____ Watering eyes or redness	____ Belching	____ Skin rashes
____ Hearing difficulties	____ Bloating	____ Psoriasis
____ Earaches or drainage	____ Abdominal pain or cramps	____ Dandruff or seborrhea
____ Noises or ringing in ears	____ Constipation	____ Hives
____ Recurrent ear infections	____ Diarrhea or loose stools	____ Itching or burning skin
____ Dental problems/ decay	____ Rectal itching	____ Easy bruising
____ Sore or bleeding gums	____ Blood with stools	____ Hypothyroid (low)
____ Sore tongue	____ Black stools	____ Hyperthyroid (high)
____ Coated tongue	____ Pain in rectum	____ Weight gain
____ Loss of taste or smell	____ Jaundice	____ Weight loss
____ Sores in or around mouth	____ Hepatitis/pancreatitis	____ Feel excessively warm
____ Difficulty swallowing	____ Colitis	____ Feel excessively cold
____ Cold sores or blisters	____ Crohn's disease	____ Loss of appetite
____ Sinus or nasal congestion	____ Diverticulitis/diverticulosis	____ Constant hunger
____ Runny nose	____ Frequent urination	____ Fatigue or weariness
____ Frequent colds	____ Brown or red urine	____ Night sweats
____ Nasal polyps	____ Decreased force of urine	____ Diabetes
____ Sore throats	____ Continual urge to urinate	____ Low blood pressure
____ Swollen glands	____ Difficulty starting urination	____ Nervousness or anxiety
____ Recurrent fevers or chills	____ Kidney or bladder infection	____ Depression
____ Hoarse voice	____ Involuntary escape of urine	____ Suicidal thoughts
____ Shortness of breath	____ Venereal disease	____ Sought psychological help
____ Wheezing or gasping	____ Aching muscles or joints	____ -MEN ONLY-
____ Coughing	____ arthritis	____ Painful testicles
____ Coughing blood	____ Joint stiffness	____ Hernia
____ Chest colds or pneumonia	____ Back or neck pain	____ Prostate problems
____ Heart murmur	____ Osteoporosis	____ Sexual dysfunction

Name: _____

Name: _____

Fill in the number that best describes your feelings most recently.

0 = not at all; 1 = a little bit; 2 = moderately; 3 = quite a bit; 4 = extremely

____ Nervousness or shakiness inside	____ Your mind is in a fog
____ Repeated unpleasant thoughts	____ Having a lump in your throat
____ Loss of sexual interest or pressure	____ Feeling tense or keyed up
____ Feeling exuberant or enthusiastic	____ Heavy feeling in your arms or legs
____ The idea that others can control your thoughts	____ Thoughts of death or dying
____ Feeling others are to blame for your troubles	____ Feeling uneasy when people are watching you
____ Trouble remembering things	____ Having to repeat the same actions over and over
____ Feeling afraid in open spaces or outside	____ Having urges to break or smash things
____ Feeling critical of others	____ Feeling self-conscious with others
____ Feeling that your goals and aims are clear in life	____ Having a good sense of humor
____ Thoughts of ending your life	____ Feeling everything is an effort
____ Hearing voices that others do not hear	____ Spells of panic or terror
____ Feeling easily annoyed or irritated	____ Getting into frequent arguments
____ Crying easily	____ Feeling relaxed
____ Feeling happy and lighthearted	____ Felling nervous when you are left alone
____ Feeling shy or uneasy with the opposite sex	____ Feeling that others do not give you proper credit for your achievements
____ Feeling of being trapped or caught	____ Feeling your life is filled with good things
____ Temper outbursts that you cannot control	____ Feeling lonely even when you are with people
____ Blaming yourself for things	____ Never feeling close to another person
____ Feeling blocked in getting things done	____ Feeling at peace with your surroundings
____ Feeling in control of your life	____ Feelings of guilt
____ Feeling lonely	____ Having the idea that something is wrong with your mind
____ Feeling blue or depressed	____ Feeling very responsible for others
____ Facing daily tasks is a source of pleasure	____ Feeling able to turn to your family for help when something is troubling you
____ Worrying too much about things	____ Feeling satisfied with your family's affection and responses to your emotional needs
____ Feeling no interest in things	____ Feeling harmony in your personal world
____ Feeling fearful or afraid	____ Feeling angry
____ Your feelings are hurt easily	____ Feeling that your ability to find meaning in life is very great
____ Others are aware of your private thoughts	____ Being a responsible person
____ Others do not understand you	____ Feeling good about your personal relationships
____ Must do things very slowly to insure correctness	____ Feeling afraid to travel by bus, train, or in cars
____ Feeling watched or talked about by others	____ Feeling your personal existence is valuable
____ Difficulty making decisions	

This index indicates degrees of stress related to changes in life. In studies, many people who scored over 300 became ill within a 3 to 6 month period. If an event has been true for you in the past year, or is about to happen, circle the associated point value. If an unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up the points.

Death of spouse or partner	100
Divorce	73
Separation from spouse or partner	65
Jail term	63
Death of a close family member	63
Personal injury or illness	53
Marriage/commitment to a partner	50
Fired at work	47
Reconciliation with a spouse/partner	45
Retirement	45
Change in health of family member	44
Pregnancy	40
Sex difficulties	39
Addition of new family member	39
Business readjustment	39
Change in financial state	38
Death of a close friend	37
Change to a different line of work	36
More arguments with spouse/partner	35
Mortgage over 50,000	31
Foreclosure of mortgage or loan	30
Change in work responsibilities	29
Child leaving home	29
Trouble with in-laws	29
Outstanding personal achievements	28
Spouse/partner begins/stops work	26
Begin or end school	26
Change in living conditions	25
Revision of personal habits	24
Trouble with boss or employee	23
Change in work hours or conditions	20
Change in residence	20
Change in schools	20
Change in recreation	19
Change in church activities	19
Change in social activities	18
Mortgage or loan under 50,000	17
Change in sleeping habits	16
Change in eating habits	15
Vacation	13
Christmas approaching	12
Minor violations of the law	11
Other	
Other	
TOTAL OF ALL POINTS	

Specify what foods and beverages you normally consume during a typical day.

Weekdays

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Weekends

Breakfast

Snack

Lunch

Snack

Dinner

Snack

Do you binge? Y N Use foods for reward or escape? Y N

If so, what foods or beverages do you use, and how often?

What foods would be most difficult to give up?

Do you have specific food cravings? Y N What Foods?

What work or scheduling considerations might create difficulties for you trying to change your eating or any other health habits?

List any known food allergies:

Name: _____

Name: _____

Please check the following boxes according to the frequency of your personal habits.

Frequent **= at least once per day;** ***Often*** **= several times per week;** ***Occasional*** **= once per week or less;**
Seldom **= once or twice per month or less;** ***Never*** **= almost total avoidance**

Frequent	Often	Occasional	Seldom	Never	
					1. Alcoholic beverages
					2. Eat at restaurants
					3. Eat at fast food restaurants
					4. Pastries, cookies, candies, ice cream, other sweets
					5. Add sugar to coffee, tea, cereals or other foods
					6. Colas or other soft drinks
					7. Instant breakfasts, pop tarts, doughnuts, muffins
					8. Cold breakfast cereals
					9. Caffeine drinks (coffee, tea, cola, chocolate)
					10. Deep fried foods
					11. Margarine of any type
					12. Whole grain hot cereals (oatmeal, wheatena, etc.)
					13. Meat (beef or veal, pork or ham, liver ,lamb)
					14. Chicken or turkey -circle : regular or free range
					15. Fresh fish
					16. Processed meat (bologna, turkey roll, sausage, etc.)
					17. Fresh raw fruit
					18. Fresh vegetables, raw or cooked
					19. Salads
					20. Whole grains or whole grain breads
					21. White bread or white flour products
					22. Beans and legumes (lentil, kidney, chickpea, etc.)
					23. Yogurt– circle: whole or low-fat, plain or flavored
					24. Milk– circle: whole or low- fat or skimmed
					25. Cheese
					26. Eggs– circle: regular or free range
					27. Salt
					28. Herbs, fresh and dried, or spices
					29. Drink adequate water—circle: tap, filtered, or bottled
					30. Eat excessively if bored or depressed
					31. Swallow food before chewing well
					32. Hurried or rushed meals
					33. Stuff yourself
					34. Read and understand food labels
					35. Sneak or hide foods
					36. Adequate fiber or roughage in the diet
					37. Artificial sweeteners (saccharin, Nutrasweet, etc.)
					38. Shop at health food stores

DO NOT PASTE OR ATTACH LABELS

INGREDIENT	AMOUNT IN MULTIPLE VITAMIN-MINERAL	AMOUNT IN INDIVIDUAL SUPPLEMENTS	DAILY TOTAL
Vitamin A			
Beta-Carotene			
Vitamin B1 (Thiamine)			
Vitamin B2 (Riboflavin)			
Vitamin B3 (Niacin)			
Vitamin B3 (Niacinamide)			
Vitamin B5 (Pantothenic Acid)			
Vitamin B6 (Pyridoxine)			
Vitamin B12 (Cobalmin)			
Vitamin C			
Vitamin D			
Vitamin E			
Vitamin K			
Biotin			
Folic Acid			
Choline			
Inositol			
Bioflavonoids			
Boron			
Calcium			
Chromium			
Copper			
Iodine			
Iron			
Magnesium			
Manganese			
Molybdenum			
Phosphorus			
Potassium			
Selenium			
Silica			
Zinc			

Name: _____

Name: _____

INGREDIENTS (Herbals, etc)	AMOUNT IN SINGLES	AMOUNT IN BLENDS	DAILY TOTAL

MEDICATIONS	DOSE	DIRECTIONS	FOR WHAT?

If you need more space add a separate sheet of paper.