Nancy E. Boyden, ARNP

Health Questionnaire

Yes, there are a lot of questions here. Don't let that overwhelm you. To help you make lasting changes, I need as much information about what you are doing now as is possible. That's why I have developed such an extensive system for learning about you. Please try to be as honest as you can, and I know that might not be easy. Just know that I am not judging you on your answers. I am going to use your answers as a starting point to creating a plan for you to change.

Name: ____ Date: ___________________

Address:		
Work #:	Home #:	Cell #:
E-mail:		
Date of Birth:	Sex: Male Female	
Ethnic/cultural background (please check what applies to you):		
☐ Caucasian ☐ Black ☐ Asian ☐ Native American		
☐ Biracial ☐ Hispanic/Latina ☐ Other: (please specify) ____________________		
Marital status (circle): Single Married Divorced Widowed Committed relationship		
Name of primary support person:		
Relationship:		
Primary support person telephone number:		
Employment status (circle): Unemployed Employed Retired Disabled		
If employed, occupation:		
Are you on medical leave: ☐ Yes ☐ No If yes, why? For how long?		
Who is your primary health care provider?		
Who referred you?		
Section 2. TODAY'S OFFICE VISIT		
What is your major complaint?		
Other complaints?		
What are your overall health goals once your complaints are resolved?		
How long has it been since you really felt good?		

What is your height?	What is your weight?
What is your maximum remembered height?	How old were you then?
What is your maximum remembered weight?	How old were you then?
What triggered your weight increase? Heredity Stress Eating Habits Boredom	
Was your weight gain: Sudden Gradual Problem since childhood	
What is your lowest remembered weight?	How old were you then?
What methods have you tried to lose/gain weight?	

Section 4. MEDICAL HISTORY

Please check if you have had problems with:

☐ Chronic cold/flu	☐ Hypoglycemia	☐ Kidney problems	☐ Osteoporosis
☐ Migraines	☐ Cholesterol	☐ Blood clots	☐ Anemia
☐ Colitis	☐ Bloody or black stools	☐ Gallbladder	☐ Endometriosis
☐ Diabetes	☐ Arthritis	☐ Seizures	☐ Cataracts
☐ Chronic Fatigue	☐ Mood swings	☐ Hair loss or growth	☐ Losing height
☐ Blood pressure	☐ Heart Attack	☐ Varicose veins	☐ Indigestion
☐ Diarrhea	☐ Hepatitis	☐ Incontinence(urine/feces)	☐ Fibroids
☐ Thyroid	☐ Muscle or joint pain	☐ Eyesight	☐ Depression
☐ Heartburn	☐ Suicidal thoughts	☐ Skin	☐ Broken bones
☐ Stroke	☐ Chest pain	☐ Easy bruising	☐ Frequent nausea
☐ Constipation	☐ Liver problems	☐ Breasts	☐ Cancer
☐ Asthma	☐ Back pain	☐ Muscular degeneration	☐ Stress
☐ Dizziness	☐ Teeth or gums	☐ Frequent falling	☐ Weight loss or gain

Section 5. LIST ANY MEDICAL PROBLEMS DIAGNOSED BY DOCTOR RECENTLY OR PAST

(Include any injuries, surgeries or hospitalizations and dates associated)

Section 6. GYNECOLOGIC HISTORY (WOMEN ONLY)

Have you ever been pregnant? ☐ Yes ☐ No # of Pregnancies ________ # of Children ________
Were pregnancies full term?... ☐ Yes ☐ No
Were deliveries….☐ Vaginal ☐ Cesarean Section ☐ Vaginal birth after C-Section

☐ Pre-menopause (before menopause; having regular periods)
☐ Peri-menopause/menopause transition (changes in periods, but have not gone 12 months in a row without a period)
☐ Post-menopause (after menopause)
Was your menopause:
☐ Spontaneous ("natural")
☐ Surgical (removal of both ovaries)
☐ Due to chemotherapy or radiation therapy; reason for therapy: ________________________
☐ Other (explain): ____

Age at first menstrual period:

Are your periods (or were your periods) usually regular?......... □ Yes □ No
Do you have a uterus?.. □ Yes □ No □ Don't Know
Do you have both ovaries? ………………………………….... □ Yes □ No □ Don't Know
Do you have a cervix? ………………………………….………. □ Yes □ No □ Don't Know
If not still having periods, what was your age when you had your last period? ___________________
If still having periods, how often do they occur? ____
How many days do your periods last? ____

Are your periods painful? □ Yes □ No If yes, how painful?.... □ Mild □ Moderate □ Severe
Do you have spotting or bleeding between periods?.......................... □ Yes □ No
Is there a recent change in how often you have periods? …………… □ Yes □ No
Is there a recent change in how many days you bleed? ……………… □ Yes □ No
Has your period recently become very heavy? ……………………….. □ Yes □ No
Do you think you have a problem with your period? …………………. □ Yes □ No
If yes, explain: ____
Do you have problems with PMS? (PMS is having mood
swings, bloating, headaches just prior to your period) ……………. □ Yes □ No
Do you examine your breasts?... □ Yes □ No
If yes, how often:__________
Did your mother take DES when she was pregnant with you?............ □ Yes □ No □ Don’t know
Do you douche? ……………………………………………………… □ Yes □ No
If yes, how often:__________
What is the date and results (if known) of your last test regarding:
Pap smear: ____________ Any abnormal Pap tests? …… □ Yes □ No If yes, when?________
Mammogram: __________ Any breast biopsies? …………. □ Yes □ No If yes, when?________
Cholesterol test: _________________ Colonoscopy: ________________________
Blood sugar test: _________________ Sigmoidoscopy: ______________________
Fecal occult blood test: ____________ Bone density test: _____________________

ABOUT MENOPAUSE AND HORMONE THERAPY

How do you view menopause?
□ Positively. Menopause means no more periods and no more worry about contraception. Menopause marks a new life phase.
□ Negatively. Menopause means a loss of fertility and loss of youth.
□ Other:
What concerns you have about menopause?

How would you rate your knowledge about menopause?
□ Very good □ Fair □ Moderately good □ Little knowledge
How do you get your information about menopause? (mark all that apply)
□ Books □ Internet □ Magazines □ Friends □ TV □ Healthcare providers
Is there anything else that you would like your healthcare provider to know?

What are your current views regarding hormone therapy for menopause?
□ Positive. Hormone therapy is appropriate for some women.
□ Negative. I don't support the use of hormone therapy.
What most concerns you about hormone therapy for menopause?

Section 7. MALE ASSESSMENT

Persistent Urinary Tract Infections	Yes	No
Adult Mumps	Yes	No
Orchitis (tesiticular inflammation)	Yes	No
Prostate Operation	Yes	No
Vasectomy	Yes	No

To what degree do you experience the following:

	None	Slight	Moderate	Severe	Extreme
Impotence					
Inability to ejaculate					
Loss of muscle mass/tone					
Fatigue or loss of energy					
Depression, low or negative mood					
Irritability, anger or bad temper					
Anxiety or nervousness					
Lack of motivation					
Loss of memory or concentration					
Dry skin on face or hands					
Weight gain					
Backache, joint pains or stiffness					

Section 8. METHODS USED

Please indicate the method of birth control, if any, that you or your partner are currently using or have used previously:

	Using Now	Previously Used		Using Now	Previously Used
None	☐	☐	Implant hormone	☐	☐
Sterilization (tubes tied)	☐	☐	Diaphragm	☐	☐
Vasectomy	☐	☐	Foam or gel	☐	☐
Birth control pill, ring, patch	☐	☐	Condoms	☐	☐
IUD	☐	☐	Natural family planning/rhythm	☐	☐
Injectable hormone	☐	☐	Other	☐	☐

Section 9. SEXUAL HISTORY

Are you currently sexually active? …………………………………… ☐ Yes ☐ No
If yes, are you currently having sex with: ☐ a man (or men) ☐ a woman (or women) ☐ Both
How long have you been with your current sex partner? ____________
Are you in a committed, mutually monogamous relationship? …… ☐ Yes ☐ No
If no, do you use condoms (practice safe sex)? …………………….. ☐ Yes ☐ No
In the past, have you had sex with: …………………….. ☐ A man (or men) ☐ A woman (or women)
Have you had any sexually transmitted infections? ………………… ☐ Yes ☐ No
Do you have concerns about your sex life? ………………………….. ☐ Yes ☐ No
Do you have a loss of interest in sexual activities (libido, desire)?.... ☐ Yes ☐ No
Do you have a loss of arousal (tingling in genitals, breasts;
vaginal moisture, warmth)? ………………………………………… ☐ Yes ☐ No
Do you have a loss of response (weaker or absent orgasm)? ……… ☐ Yes ☐ No
Do you have any pain with intercourse (vaginal penetration)? …….. ☐ Yes ☐ No
If yes, how long ago did the pain start? ____________________
Please describe the pain: ☐ Pain with penetration ☐ Pain inside ☐ Feels like sandpaper

Section 10. ALLERGY INFORMATION

Are you allergic to any medications? ☐ Yes ☐ No ☐ Don't know If yes, please indicate which one(s)

Medication:	Reaction:	Date of onset:
Medication:	Reaction:	Date of onset:
Medication:	Reaction:	Date of onset:

Do you have any other allergies? ☐ Yes ☐ No ☐ Don't know If yes, please indicate which one(s)

To what?	Reaction:	Date of onset:
To what?	Reaction:	Date of onset:

Section 11. MEDICATION HISTORY

Are you currently using hormone therapy for menopause? ☐ Yes ☐ No
If no, why not?

If yes, for what reason(s)?

Please indicate the medications and supplements you are currently using. Include prescription drugs and those purchased without a prescription, such as vitamins and calcium. Also include all hormone therapy you have used in the past (ex: contraceptives and hormone therapy for menopause).

Medication:	Dose:	Frequency:	Date Started:	Date Stopped:	Why:

Have you used any other therapy for menopause (such as soy, vitamins, herbs, supplements, foods, yoga)?
☐ Yes ☐ No If yes, please indicate:

Of these, what are you currently using?

Is this therapy helpful? ☐ Yes ☐ No

Section 12. FAMILY HISTORY

Please list family member (i.e., mother, father, sister, brother, maternal/paternal grandparent) who has or has had the following, include dates(if known), duration(if applicable):

High blood pressure: ____________________________
Heart attack: ____________________________
Stroke (indicate age): ____________________________
Blood problems
including sickle cell trait): ____________________________
Blood clots: ____________________________
Bleeding tendency: ____________________________
Glaucoma: ____________________________
Osteoporosis: ____________________________
Hip fracture: ____________________________
Diabetes: ____________________________
Breast Cancer (indicate age): ____________________________

Colorectal cancer: ____________________________
Ovarian cancer: ____________________________
Other cancer: ____________________________
Depression: ____________________________
Other emotional problems: ____________________________
Alzheimer's disease: ____________________________
Domestic violence victim: ____________________________
Domestic Violence person: ____________________________
Sexual Abuse victim: ____________________________
Sexual Abuse person: ____________________________
Alcoholism: ____________________________
Drug abuse: ____________________________

Is there anything about your family's health history that concerns you, or that you would like to discuss?
☐ Yes ☐ No If yes, what?

Section 13. PERSONAL HABITS

Do you consider your health to be : ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Exercise

How often do you exercise? ☐ At least 3 times a week ☐ Occasionally ☐ Rarely ☐ Never

If you exercise, what do you do? ____

For how long and how often? _____________________________________

In your estimation, how physically fit are you right now?

Unfit ____ Below average ____ Average ____ Above Average ____ Very fit ____

If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

What are your fitness goals? (check all that apply)

____ General fitness endurance ____ Muscle Toning

____ Weight loss/maintain weight ____ Muscle Strengthening

____ Osteoporosis prevention ____ Muscular Coordination/Balance

____ Specific sport enhancement ____ Flexibility

____ Other: __________________________________

How is your energy level?

Is there times in the day that you feel best? Worst?

Diet

How many meals do you consume each day? _____________________________________

Do you try to eat a low-fat diet? ☐ Yes ☐ No

What dairy products do you consume each day?

☐ Milk How much? _______________ ☐ Yogurt How much? ____________________

☐ Cheese How much? ____________ ☐ Other _____________________________

Are you lactose intolerant (have a milk allergy) ☐ Yes ☐ No

How many servings of fruits do you consume each day? ______________________________

How many servings of vegetables do you consume each day? __________________________

How many servings of soy foods do you consume each day? ___________________________

Are there foods that you eat on a daily basis, almost daily basis?

Tobacco use (Includes cigarettes, chewing tobacco, and all electronic vapor usage)

Do you currently use tobacco products? ☐ Yes (include type)_______________ ☐ No

If yes, how much/many per day? _____________ When did you start?_____________________

How do you feel about quitting? ____

Have you ever used tobacco products?.... ☐ Yes (include type)_________________ ☐ No

If yes, when did you start? _________ How many per day? ________ When did you stop: ______

Caffeine use

Do you consume drinks with caffeine (coffee, tea, soda drinks)? ….. ☐ Yes ☐ No

If yes, how many drinks each day? ______________________

Alcohol and drug use

Do you drink alcohol? ………………………………………………….. ☐ Yes ☐ No

If yes, how many drinks do you have each week? ________________

Do you ever have a drink in the morning to help you get going? ……..	☐ Yes	☐ No
Have you ever tried to cut down on your drinking? ……………………..	☐ Yes	☐ No
Have you ever felt guilty about the amount you drink? ………………..	☐ Yes	☐ No
Have you ever been an alcoholic? ………………………………………..	☐ Yes	☐ No
Do you use recreational drugs? …………………………………………..	☐ Yes	☐ No
Type:_________________________ How often:______________________________		
Abuse		
Within the last year, have you been hit, slapped, kicked,		
or otherwise physically hurt by someone?....................................	☐ Yes	☐ No
Within the last year, has anyone ever forced you to engage		
in sexual activities? …………………………………………………..	☐ Yes	☐ No
Do you feel you are verbally or emotionally abused by someone? …...	☐ Yes	☐ No
Have you had counseling for these issues? ……………………………..	☐ Yes	☐ No
Stress management		
What are the current major stressors or life changes in your life?		
Any major changes in family health during the past year? …………...	☐ Yes	☐ No
If yes, explain:		
How do you handle stress? ☐ Very well ☐ Moderately well ☐ Poorly		
What do you do to relax?		
What are your main sources of stress?		
Are you happy in your life right now?		
How much sleep do you get each night on average?		

Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life?			**Do you often?**		
Now	Past	**Satisfactory**	Now	Past	**Feel Depressed**
Now	Past	**Boring**	Now	Past	**Have Anxiety**
Now	Past	**Demanding**	**Have you?**		
Now	Past	**Unsatisfactory**	Now	Past	**Seriously considered suicide**
Do you worry over?			Now	Past	**Attempted suicide**
Now	Past	**Home life**	**Do you often?**		
Now	Past	**Marriage**	Now	Past	**Have irrational fears**
Now	Past	**Children**	Now	Past	**Feel upset**
Now	Past	**Job**	Now	Past	**Feel things go wrong**
Now	Past	**Income**	Now	Past	**Feel shy**
Now	Past	**Money Problems**	Now	Past	**Cry**

Section 14. SYMPTOMS

Please indicate how bothered you are now and in the past few weeks by any of the following:

	Not at all	A little bit	Quite a bit	Extremely
I have hot flashes	☐	☐	☐	☐
I have night sweats	☐	☐	☐	☐
I have difficulty getting to sleep	☐	☐	☐	☐
I get heart palpitations or a sensation of butterflies in my chest or stomach	☐	☐	☐	☐
I feel like my skin is crawling	☐	☐	☐	☐
I feel more tired than usual	☐	☐	☐	☐

	Not at all	A little bit	Quite a bit	Extremely
I have difficulty concentrating	☐	☐	☐	☐
My memory is poor	☐	☐	☐	☐
I am more irritable than usual	☐	☐	☐	☐
I feel more anxious than usual	☐	☐	☐	☐
I have more depressed moods	☐	☐	☐	☐
I am having mood swings	☐	☐	☐	☐
I have crying spells	☐	☐	☐	☐
I have headaches	☐	☐	☐	☐
I need to urinate more often than usual	☐	☐	☐	☐
I leak urine	☐	☐	☐	☐
I have pain or burning when urinating	☐	☐	☐	☐
I have bladder infections	☐	☐	☐	☐
I have uncontrollable loss of stool or gas	☐	☐	☐	☐
My vagina is dry	☐	☐	☐	☐
I have vaginal itching	☐	☐	☐	☐
I have an abnormal vaginal discharge	☐	☐	☐	☐
I have vaginal infections	☐	☐	☐	☐
I have pain during intercourse	☐	☐	☐	☐
I have pain inside during intercourse	☐	☐	☐	☐
I have bleeding after intercourse	☐	☐	☐	☐
I lack desire or interest in sexual activity	☐	☐	☐	☐
I have difficulty achieving orgasm	☐	☐	☐	☐
My opportunity for sexual activity is limited	☐	☐	☐	☐
My stomach feels like it's bloated or I've gained weight	☐	☐	☐	☐
I have breast tenderness	☐	☐	☐	☐
I have joint pains	☐	☐	☐	☐

Section 15. RISK ASSESSMENT

The following questions will help determine your risk for disease later on in life.
Please check all that apply to you.

Osteoporosis risk:

- ☐ Bone density test shows low bone mass
- ☐ Bone density test shows osteoporosis
- ☐ Family history of osteoporosis
- ☐ Small, thin frame
- ☐ Caucasian or Asian
- ☐ Missed menstrual period for 6 months or more (not including when pregnant or breastfeeding
- ☐ Diet low in milk and dairy products
- ☐ Do not take calcium supplements
- ☐ Taking thyroid, anti-seizure, anticoagulant, or cortisone medication
- ☐ Menopause before age 40
- ☐ More than 7 alcoholic drinks each week
- ☐ Prolonged bed rest
- ☐ Exercise less than 3 times a week

□ Cannot rise from chair without using arms
□ Cannot rise from floor without difficulty
□ Frequent falls
□ Previous episodes of severe dieting, bulimia, or anorexia
□ Hemophilia
□ Type I diabetes
□ Chronic liver or kidney disease
□ Crohn's disease
□ Rheumatoid arthritis
□ Current smoker
□ Spend little or no time in sunlight and don't take vitamin D
□ Loss of height greater than 1.5 inches
□ Previous fracture
□ More than one previous fracture
□ Scoliosis
□ Back Pain
□ Gum disease or tooth loss

Cardiovascular Risk:

□ Previous heart attack
□ Previous stroke
□ Previous or current chest pain (angina)
□ Previous or current heart rhythm problem (arrhythmia)
□ Diabetes
□ High Blood Pressure
□ High total cholesterol
□ Low HDL (good cholesterol)
□ High triglycerides
□ Current smoker
□ Over 65 years old
□ Black skin color
□ More than 30% over ideal weight (i.e., should be 120 pounds, but now weigh 160; should be 150, but now 200)
□ My shape is like an apple (waist bigger than hips)
□ Exercise less than 3 times a week
□ Have not cut down on fat in my diet
□ Family history of heart disease

Cancer Risk:

A. Cervical cancer risk

□ Smoking
□ Genital warts (HPV)
□ Abnormal Pap test
□ Sexual intercourse at an early age
□ Multiple sexual partners
□ Sexual partners who have had multiple sexual partners
□ HIV
□ Have unsafe sex (without a condom)

B. Uterine cancer risk:
If you no longer have a uterus, skip to Breast cancer risk.
□ More than 30% over ideal body weight (i.e. Should be 120 pounds, but now weigh 160)
□ Unexplained uterine bleeding
□ Prolonged time spans with out menstrual periods Except when pregnant
□ Have not given birth
□ Began menstrual periods before age 12
□ Reached menopause after age 53
□ Diabetes
□ Gallbladder disease
□ Use of tamoxifen
□ Use of estrogen therapy for menopause without adding a progestogen (unopposed ERT)

C. Breast Cancer Risk:
□ Mother or sister diagnosed with breast cancer before Menopause
□ Previous breast, uterine, or ovarian cancer
□ Positive BRCA1 (gene mutation)
□ Reached menopause after age 55
□ Began menstrual periods before age 12
□ Had first child over age 30
□ No children
□ More than 30% over ideal weight after menopause (i.e. Should be 120 pounds, but now weigh 160; should be 150 pounds, but now weigh 200.)
□ Drinking more than 7 alcoholic drinks each week
□ Lack of exercise
□ Diet low in vegetables and fruits
□ Have used estrogen therapy more than 5 years

D. Ovarian cancer risk:
□ No children
□ Previous breast or uterine cancer
□ Family history of ovarian, breast or uterine cancer
□ Positive BRCA1 and BRCA2

E. Colorectal cancer risk:
□ History of colorectal cancer or adenomatous polyps
□ Family history of colorectal cancer or adenomatous Polyps
□ Inflammatory bowel disease
□ Diet low in vegetables, fruits and fiber
□ Smoking

F. Lung cancer risk:
□ History of lung cancer
□ Family history of lung cancer
□ Current smoker

□ Previous smoker
□ Smoker in home
□ Smoker(s) at work
□ Work around asbestos or talc
□ Work around cancer-causing chemicals (gasoline, diesel exhaust, arsenic, uranium, vinyl chloride, nickel chromates, coal products, mustard gas, chloromethyl ethers)
□ Exposure to radon gas
□ Smoke marijuana
□ History of tuberculosis

G. Skin cancer risk:
□ Light skin color
□ Previous skin cancer
□ Family history of skin cancer
□ Severe sunburn(s) when a child
□ Numerous moles and freckles
□ Sunbathe regularly or for longer than 1-hour sessions
□ Visit tanning salons

____ ____________________

Patient Signature Date

____ ____________________

Practitioner Signature Date