LifeTime Health Center
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Dear Patient,
We have designed this questionnaire to learn more about you in order to assist you in achieving your optimum health. We believe a woman's lifestyle, habits, work history and other characteristics are a vital part of the health assessment and your participation in this process will help us better evaluate your test results, risk factors and preventative needs. This information will be placed in a secure file and will NOT be shared with anyone including your insurance company or other entities requesting medical records. If you are uncomfortable answering any of the questions, please feel free to leave the answer blank.

Sincerely,
Rene' McCarty. PAC
Wendy Freden, PAC
Carlyn Graff, FNP

Date: _____

Name: _____ Age_____

Allergies: _____

Medications (Include prescriptions, non-prescriptions, herbs and supplements):_____
_____
_____
_____

Reproductive Health
I started periods at age____.
Are you currently using contraceptives? What kind:_____Tubal?_____
Are you currently trying to get pregnant? _____
First Pregnancy: Age_____ Prenatal Care? _____ Describe course and outcome:
Miscarriage,abortion,vaginal birth or Csection:_____
_____
Second Pregnancy: Age: ____ Prenatal Care? _____ Describe Pregnancy: _____
_____
Third Pregnancy: Age____ Prenatal Care? ____ Describe pregnancy: _____
_____
Other Pregnancies: _____
_____
Infertility Treatments? _____
My menstrual periods are: Regular (occurring every 28-32 days) _____ or Irregular (describe)_____

Days of flow per period_____ Flow is: light____ moderate____heavy____
My periods stopped at age_____
Describe symptoms during the week of your period: (headaches, backaches, cramping, fatigue, etc.) _____
_____
Have you ever had cysts of the ovaries? _____
Have you ever had cancer of the female organs? _____
Have you ever had abnormal Pap smears?_____ Describe treatment and the diagnosis:_____
When was your last pap smear? _____
Have you ever had problems with the uterus such as abnormal bleeding or fibroids? __
_____
Have you had a hysterectomy? ____ Do you still your ovaries? _____
When did you have it? _____
Have you had problems with the vulva or vagina? _____

Breast Health
Do you perform self-breast exam? ____ How often? _____
Do you have breast pain, tenderness or discharge? _____
Date of last mammogram? _____
Have you ever had a breast biopsy? _____
Have you ever been diagnosed with breast cancer?_____ Describe diagnosis and treatment:_____
Have you ever had breast reduction or augmentation (implants)? _____
_____

Sexuality
Are you sexually active? _____ Do you have intercourse? _____
Do you practice safe sex? _____ Are you in a long-term relationship? ___ How long? __
How would you rate your level of sexual interest or desire? _____
How satisfied are you with your overall sexual life? _____
Do you have any other sexual concerns to discuss? _____

Hormonal Symptoms
Mood Changes:
1. Anxiety (feeling of worry, panic out of proportion to usual worries)? Yes__ No__
2. Tearfulness (crying more often or easily)? Yes__ No__
3. Irritability (more short with coworkers, spouse or children)? Yes__ No__
4. Mood swings (angry, sad, happy, anxious)? Yes__ No__
5. Tension (feeling more nervous and tense at work and home)? Yes__ No__
6. Depressed (feeling down, sad, blue)? Yes__ No__

Behavior Changes:
1. Outbursts of anger and rage Yes__ No__
2. Impulsive acts (acting or speaking without thinking of consequences)? Yes__ No__
3. Fatigue (lack of energy, excessive tiredness)? Yes__ No__
4. Craving for sweets or chocolate? Yes__ No__
5. Craving for bread or alcohol? Yes__ No __
6. Craving for salty food? Yes__ No__

Body Changes:

1. Weight gain? Yes__ No__
2. Breast tenderness? Yes__ No__
3. Bloating? Yes__ No__
4. Constipation? Yes__ No__
5. Dizziness? Yes__ No__
6. Low back pain, joint pain? Yes__ No__
7. Headaches? Yes__ No__
8. Heart pounding, beating harder? Yes__ No__
9. Swelling of hands and feet? Yes__ No__
10. Loss of luster to skin, hair, nails? Frequent__ Occasional__Rare__
11. Dryness of skin, vagina Frequent__ Occasional__Rare__
12. Hot flushes or flashes? Frequent__ Occasional__Rare__
13. Sweats, followed by being chilled? Frequent__ Occasional__Rare__
14. Pain or aches in joints or muscles? Frequent__ Occasional__Rare__
15. Pounding heartbeat of flutters? Frequent__ Occasional__Rare__
16. Skin sensations of crawling insects? Frequent__ Occasional__Rare__
17. Dizziness? Frequent__ Occasional__Rare__
18. Vaginal burning or itching? Frequent__ Occasional__Rare__
19. Pain with urination? Frequent__ Occasional__Rare__
20. Increased frequency of urination? Frequent__ Occasional__Rare__
21. Leaking of urine? Frequent__ Occasional__Rare__
22. Increased urge to urinate? Frequent__ Occasional__Rare__
23. Scalp hair loss? Yes__ No__
24. Sexual interest? Normal__ Decreased__
25. Orgasm? Normal__ Decreased__
26. Pain with sex? Yes__ No__

Brain Changes:

1. Change in appetite? Yes__ No__
2. Poor sleep, restless, not restorative? Yes__ No__
3. How many hours do you sleep at night? _____
4. Change in coordination? Yes__ No__
5. Forgetfulness? Yes__ No__
6. Difficulty in concentrating, staying focused? Yes__ No__
7. Difficulty in decision making? Yes__ No__
8. Memory problems? Yes__ No__

Cardiovascular Health

Do you have any heart problems? _____
Do you have high blood pressure? _____
Have you ever been diagnosed with a heart attack? _____
Have you ever been diagnosed with heart failure or heart rhythm problems? _____
_____
Have you ever had a blood clot of the leg, arm, or lung? _____
Other cardiovascular concerns? _____
Do you smoke, vape or use other forms of nicotine? _____

Musculoskeletal Health

Have you ever been diagnosed with a connective tissue, joint, bone or muscle disease?
_____
Have you ever had a bone density test? _____ Results? _____
Do you take over-the-counter or prescription pain medicine? Yes___ No___
What and how much? _____
Have you reduced or limited activities due to pain? _____

Digestive and Nutritional Health
Have you ever been diagnosed with an illness of the liver, gall bladder, esophagus, pancreas or intestines? _____
Have you had bariatric surgery-Bypass, Lap Band, Gastric Sleeve, etc._____
Do you have difficulty swallowing pills or capsules? _____
Do you have indigestion or reflux? _____
Do you take over the counter medications or herbs for digestive symptoms? _____
Describe: _____
Are you satisfied with your current body weight? Yes___ No___
Do you feel fat most of the time? Yes___ No___
Do you restrict the amount of food you eat to control your weight? Yes___ No___
Are you preoccupied with your weight? Yes___ No___
Do you exercise to keep your weight down? Yes___ No___
Do you feel ashamed about your eating habits? Yes___ No___

Describe your typical diet and food choices:
Breakfast: _____
Lunch_____
Dinner_____
Snacks_____
Caffeine intake_____ Carbonated beverages_____

Skin Health
Have you ever had skin lesions removed? _____
Do you bruise easily? _____
Do you experience dryness or wrinkling of the skin? _____
Do you have dark spots on the face or arms? _____
Any changes in your skin, hair or nails? _____

Headache Questionnaire
Please complete if headaches are a problem for you.
Describe location and type of headache pain: _____
_____
Do foods or chemicals cause your headaches? _____
Are headaches connected to the menstrual cycle? _____
What time of the day do headaches occur? _____
How frequently do headaches occur? _____
How long do headaches last? _____
What relieves the headaches? _____
How long have you been experiencing headaches? _____
With the headache, do you experience sensitivity to light, loud noise or smells? _____
_____

Does stress worsen your headaches? _____
What sort of medical treatment have you received for headaches? _____
_____
Are headaches associated with numbness or weakness of the arms, legs or face? _____
_____
Do you have changes in vision associated with headaches? _____
Do you take over the counter medicine for headache? How Much? _____
_____

Stress Scale

Please answer and score each answer as directed.

___ Give yourself 10 pts if you feel you have a supportive family member near you.
___ Give yourself 10 pts if you actively pursue a hobby. What is it? _____
___ Give yourself 10 pts if you belong to a social group or activity group outside of your family that meets at least monthly. What group? _____
___ Give yourself 15 pts if you are within five pounds of your ideal body weight for your height and bone structure.
___ Give yourself 15 pts if you practice some form of “deep relaxation” at least three times a week (meditation, prayer, yoga, imagery).
___ Give yourself 15 pts for each time you exercise 30 mins or more during the week.
___ Give yourself 5 points for each nutritionally balanced meal you consume on an average day.
___ Give yourself 5 pts if you do something that you enjoy that is just for your pleasure each week.
___ Give yourself 10 pts if you have someplace in your home that you can relax and be alone.
___ Give yourself 10 pts if you practice time management techniques in your daily life.
___ Subtract 10 pts for each pack of cigarettes you smoke in an average day.
___ Subtract 5 pts for each evening in the course of an average week that you take any form of medication, chemicals or alcohol to help you sleep.
___ Subtract 10 pts for each day during the course of an average week that you consume any form of medication, chemical substance or alcohol to reduce your anxiety or help calm you down.
___ Subtract 5 pts for each evening during the course of an average week that you bring work home.
___ Subtract 5 pts for each day during the course of an average week that you overeat or binge to cope with feelings of anger, anxiety or depression.
_____ Total Score. (Maximum 115)

Well-Being Assessment

What are 5 things that you like about yourself? _____
_____
_____
What are 5 things that you feel you do well? _____
_____
_____

What are 5 things you are not happy with and want to change? _____
_____
_____
What are your most important aspirations? _____
_____
What are some self-destructive or self-defeating behaviors that you want to stop?_____
_____

What are several things that you tell yourself that you “should” do or “ought to” do that you really do not want to do?_____
_____
_____

Habits and Lifestyle
Who lives in your household? _____
Any pets? _____
Do you drink alcohol to excess or use mood altering drugs more than 3-4 times a year?
_____
How many hours of television do you watch a day? _____

Occupational Health
What is your current occupation or occupation prior to retirement? _____
_____
Describe you education. _____
Describe your work or volunteer environment. _____
_____
How many hours a week do you work or volunteer? _____
Are you satisfied with your work or volunteer situation? _____

Spiritual Travel
What in your life gives you internal support? _____
What are your sources of hope, strength, comfort and serenity? _____
_____
_____
Are you worried about any conflicts between your beliefs and your medical care or medical decisions made by your providers? _____
_____
Are there any practices or restrictions I should know about as your healthcare provider?
_____
Have you made plans for end of life care? _____

Conclusion
Is there anything else that you wish to share about your past or present health concerns? _____
_____
_____
_____
_____