



# HEALTH HISTORY for WOMEN



Please mark an X on the scales and check any boxes of symptoms you have had in the past month

**TEMPERATURE**

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

<p style="text-align: center;"><b>COLD</b></p> <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Chills <input type="checkbox"/> Cold "in the bones" <input type="checkbox"/> Areas of numbness	<input type="checkbox"/> Thirst for cold / hot drinks <input type="checkbox"/> Thirst, no desire to drink <input type="checkbox"/> Absence of thirst <input type="checkbox"/> Excessive thirst	<p style="text-align: center;"><b>HOT</b></p> <input type="checkbox"/> Night sweats <input type="checkbox"/> Unusual sweats <i>When _____ am / pm</i> <i>Where on body _____</i> <input type="checkbox"/> Hot hands, feet, chest <input type="checkbox"/> Hot flashes <input type="checkbox"/> Hot in afternoon <input type="checkbox"/> Hot at night
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**MOISTURE**

Your overall body moisture (hair, skin, mouth, bowels, etc.)

<p style="text-align: center;"><b>DRY</b></p> <input type="checkbox"/> Dry skin <input type="checkbox"/> Dry hair <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry brittle nails	<input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry lips <input type="checkbox"/> Dry throat <input type="checkbox"/> Dry nose / Nosebleeds	<p style="text-align: center;"><b>OILY</b></p> <input type="checkbox"/> Oily skin <input type="checkbox"/> Oily hair <input type="checkbox"/> Pimples <input type="checkbox"/> Weight gain / loss
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Where on your body?:  
 Edema / Swelling \_\_\_\_\_  
 Rashes \_\_\_\_\_  
 Itching \_\_\_\_\_  
 Dandruff \_\_\_\_\_

**DIGESTION**

<p style="text-align: center;"><b>DIARRHEA</b></p> <p>BM: How often? _____ x / every _____ days</p> <p>Stools keep shape?    <input type="checkbox"/> Y    <input type="checkbox"/> N</p> <input type="checkbox"/> Alternating diarrhea & constipation (IBS) <input type="checkbox"/> Indigestion	<input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Poor appetite	<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bad breath <input type="checkbox"/> Heartburn <input type="checkbox"/> Excessive hunger
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<p style="text-align: center;"><b>CONSTIPATION</b></p> <input type="checkbox"/> Dry Stools <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Tired after BM <input type="checkbox"/> Foul smelling stools
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**ENERGY**

<p style="text-align: center;"><b>LOW</b></p> <input type="checkbox"/> Sudden energy drop <i>Time of day: _____ am / pm</i> <input type="checkbox"/> Energy drop after eating <input type="checkbox"/> Fatigue	<input type="checkbox"/> Dependence on caffeine / stimulants <input type="checkbox"/> Wired / ungrounded feeling <input type="checkbox"/> Body / Limbs feel heavy <input type="checkbox"/> Body / Limbs feel weak	<p style="text-align: center;"><b>HIGH</b></p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Blood pressure High / Low <input type="checkbox"/> Bleed / Bruise easy <input type="checkbox"/> Hard to concentrate <input type="checkbox"/> Poor memory <input type="checkbox"/> Dizziness / lightheaded <input type="checkbox"/> Headaches _____ x / week
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**SLEEP**

# hours per night \_\_\_\_\_

 Difficulty falling asleep  
 Wake \_\_\_\_\_ x / night @ \_\_\_\_\_ am / pm  
 Wake to urinate *How often?* \_\_\_\_\_  
 Disturbing dreams  
 Restless sleep  
 Not rested upon waking

**EMOTIONS**

What emotion(s) dominate your experience?

<input type="checkbox"/> Anger	<input type="checkbox"/> Grief
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Joy
<input type="checkbox"/> Worry	<input type="checkbox"/> Fear
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Timid / shy
<input type="checkbox"/> Sadness	<input type="checkbox"/> Indecision

**EYES, EARS NOSE THROAT**

<input type="checkbox"/> Poor vision	<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Night blindness	<input type="checkbox"/> Ringing in ears
<input type="checkbox"/> Red eyes	<input type="checkbox"/> Excess earwax
<input type="checkbox"/> Itchy eyes	<input type="checkbox"/> Sore throat
<input type="checkbox"/> Spots in front of eyes	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Sinus congestion	<input type="checkbox"/> Mouth sores
<input type="checkbox"/> Phlegm (color _____)	<input type="checkbox"/> Cough

**MENSES**

Age at first menses: \_\_\_\_\_

Length of full cycle: \_\_\_\_\_ days

Length of menses: \_\_\_\_\_ days

Last menses start date: \_\_\_\_\_ / \_\_\_\_\_

# of pregnancies: \_\_\_\_\_

# of births: \_\_\_\_\_ premature \_\_\_\_\_

# of abortions / miscarriages: \_\_\_\_\_

**MENOPAUSE**

Age at last menses : \_\_\_\_\_     Hot flashes \_\_\_\_\_ x / day     Vaginal dryness

Year changes began: \_\_\_\_\_     Night sweats \_\_\_\_\_ x / week     Loss of sex drive

<input type="checkbox"/> Heavy periods	<input type="checkbox"/> Cramps	<input type="checkbox"/> Mood changes
<input type="checkbox"/> Light periods	<input type="checkbox"/> Before bleeding	<input type="checkbox"/> Fatigue w/ menses
<input type="checkbox"/> Painful periods	<input type="checkbox"/> First day	<input type="checkbox"/> Digestive changes w/ menses
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> During period	<input type="checkbox"/> Midcycle spotting
<input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS)	<input type="checkbox"/> Clots	<input type="checkbox"/> Yeast infections
	<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Birth control pill (hormonal)