COURI CENTER
for Gynecology and Integrative Women's Health

INTEGRATIVE MEDICINE FORM

GENERAL INFORMATION

Name *(First)* _____ *(M)*_____ *(Last)*_____

Preferred Name *(Nickname)*_____ Date of Birth _____ Age _____

Address *(Street)*_____(City)_____(Zip)_____

Home phone _____ Cell Phone _____ Work Phone _____

Email address _____

Employer _____ Job title _____

Highest Level of Education: ( ) High school ( ) Graduate ( ) Post-Graduate

Genetic Background: ( ) African ( ) Asian ( ) European ( ) Ashkenazi ( ) Native American

( ) Middle Eastern ( ) Mediterranean ( ) _____

Emergency Contact *(Name)* _____ *(Phone #)*_____

(Address) _____

Primary Care Physician _____ *(Phone #)*_____

Referred by: ( ) Website ( ) Friend or Family Member ( ) Physician ( ) _____

Primary Pharmacy *(Name)*_____ *(Location)*_____

Compounding/Supplement Pharmacy *(Name)*_____ *(Location)*_____

MEDICAL QUESTIONNAIRE

Allergies: Name of Medication/Supplement/Food Reaction

_____ _____

_____ _____

_____ _____

Complaints/Concerns:

What do you hope to achieve in your visit with us? _____

_____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel better? _____

_____

What makes you feel worse? _____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

MEDICATIONS

Medication/Supplement	Dose	Frequency	Start Date	Reason For Use

Have you had a prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? _____

Frequent antibiotics (>3 a year)? _____ Long term antibiotics? _____ Use of steroids? _____

GYNECOLOGIC HISTORY

OBSTETRIC HISTORY *(Check if yes and provide number of)*

( ) Pregnancies _____ ( ) Caesarean _____ ( ) Vaginal Deliveries _____ ( ) Miscarriage _____

( ) Abortion _____ ( ) Living Children _____ ( ) Post Partum Depression ( ) Toxemia

( ) Gestational Diabetes ( ) Baby over 8 pounds ( ) Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at first period: _____ Menses occurs every_____days, and lasts _____ days.

Painful? _____ Clotting? _____ Has your period ever skipped? _____ How long? _____

Last Menstrual Period: _____ Do you use contraception? _____ If yes, please mark:

( ) Birth Control Pills ( ) Patch ( ) Nuva Ring ( ) Condom ( ) Diaphragm ( ) IUD ( ) Partner Vasectomy

If pills, patch or Nuva Ring, how long? _____

Are you in menopause? _____ If yes, age at menopause: _____

Do you have *(check all that apply):*

( ) Fibrocystic Breasts ( ) Endometriosis ( ) Fibroids ( ) Infertility ( ) Painful Periods ( ) Heavy Periods

( ) PMS ( ) Hot Flashes ( ) Mood Swings ( ) Concentration/Memory Problems ( ) Vaginal Dryness

( ) Decreased Libido ( ) Joint Pains ( ) Headaches ( ) Weight Gain ( ) Loss of Bladder Control ( ) Palpitations

Do you use hormone replacement therapy? _____ If yes, how long? _____

Have you had a hysterectomy? _____ If yes, when? _____ ( ) Vaginal ( ) Abdominal

DATE OF LAST: Mammogram _____Normal PAP Test _____/Abnormal PAP _____

Bone Density _____ Colonoscopy _____

Blood Tests for: Cholesterol _____ Glucose _____ Thyroid_____

Full Physical Exam _____ Salivary testing _____

Were any of these abnormal? _____ If yes, give details: _____

_____

_____

MEDICAL HISTORY

HOSPITALIZATIONS: ( ) None

Date	Reason

SURGERIES (check all that apply and give date): ( ) None

X	Type	Date
	Appendectomy	
	Hysterectomy	
	Ovaries (which side or both?)	
	Bladder surgery for incontinence	
	Gall Bladder	
	Joint Replacement – Knee/Hip	
	Heart Surgery-Bypass/Valve	
	Angioplasty/ Stent / Pacemaker	
	Other	

FAMILY HISTORY (Indicate who in your family, besides yourself, has had these conditions):

Colon Cancer _____ Breast Cancer _____

Ovarian Cancer _____ Heart Disease _____

Obesity _____ High Blood Pressure _____

Diabetes _____ Stroke _____

SOCIAL HISTORY

NUTRITION HISTORY:

Have you ever had a nutrition consultation? _____

Have you made any changes in your eating habits because of your health?_____ Describe: _____

Do you currently follow a special diet or nutritional program? _____ *(Check all below that apply:)*

( ) Low Fat ( ) Low Carbohydrate ( ) High Protein ( ) Low Sodium ( ) Diabetic ( ) No Dairy ( ) No Wheat

( ) Gluten Restricted ( ) Vegetarian ( ) Vegan ( ) Ultrametabolism ( ) Other _____

Height _____	Current Weight _____
Usual weight range +/- 5 lbs_____	Desired weight range _____
Highest adult weight _____	Lowest adult weight _____
Weight Fluctuations (> 10 lbs) ( ) YES ( ) NO	Body Fat % _____

How often do you weigh yourself? _____ Do you read food labels? _____

Have you ever had your metabolism (resting metabolic rate) checked? _____ Result: _____

Do you avoid any particular foods? _____ If yes, types and reason _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? _____ If no, who does the shopping? _____

Do you cook? _____ If no, who does the cooking? _____

How many meals do you eat out per week? ( ) 0-1 ( ) 2-3 ( ) 4-5 ( ) more than 5 per week

Check all the factors that apply to your current lifestyle and eating habits:

( ) Fast eater ( ) Erratic eating pattern ( ) Eat too much ( ) Late night eating ( ) Dislike healthy food

( ) Time constraints ( ) Eat more than 50% meals away from home ( ) Travel frequently

( ) Non-availability of healthy foods ( ) Do not plan meals or menus ( ) Reliance on convenience items

( ) Poor snack choices ( ) Significant other doesn't like healthy foods ( ) Love to eat

( ) Significant other has special dietary needs or food preferences ( ) Eat because I have to

( ) Have a negative relationship with food ( ) Struggle with eating issues ( ) Emotional eater

( ) Eat too much under stress ( ) Eat too little under stress ( ) Don't care to cook

( ) Eating in the middle of the night ( ) Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____

_____

Currently smoking? ( ) Yes ( ) No If yes, how many years? _____ Packs per day: _____

Attempts to quit: _____'

Previous smoking: How many years? _____ Packs per day? _____ When did you quit? _____

2nd hand smoke exposure? ( ) Yes ( ) No

How many alcoholic drinks do you have per week? ( ) None ( ) 1-3 ( ) 4-6 ( ) 7-10 ( ) >10

Caffeine intake*: (Mark how many cups per day of each type)* Coffee/Tea ( ) 1 ( ) 2-4 ( ) > 4 a day

Caffeinated soda or diet soda ( ) 1 ( ) 2-4 ( ) > 4 a day Favorite type: _____

Are you currently using any recreational drugs? ( ) Yes ( ) No If yes, what type? _____

Have you ever used IV or inhaled recreational drugs? ( ) Yes ( ) No

EXERCISE: Current exercise program:

ACTIVITY	TYPE	FREQUENCY PER WEEK	DURATION IN MINUTES
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, etc)			
Sports (golf, tennis, etc)			

Rate your level of motivation for including exercise in your life: ( ) Low ( ) Medium ( ) High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? ( ) Yes ( ) No

Do you usually sweat when exercising? ( ) Yes ( ) No

READINESS ASSESSMENT *(Rate on a scale of: 5 (very willing) to 1 (not willing).*

In order to improve your health, how willing are you to:

Significantly modify your diet ( ) 5 ( ) 4 ( ) 3 ( ) 2 ( ) 1

Take several nutritional supplements each day ( ) 5 ( ) 4 ( ) 3 ( ) 2 ( ) 1

Keep a record of everything you eat each day ( ) 5 ( ) 4 ( ) 3 ( ) 2 ( ) 1

Modify your lifestyle (e.g. work demands, sleep habits) ( ) 5 ( ) 4 ( ) 3 ( ) 2 ( ) 1

Practice a relaxation technique ( ) 5 ( ) 4 ( ) 3 ( ) 2 ( ) 1

Engage in regular exercise ( ) 5 ( ) 4 ( ) 3 ( ) 2 ( ) 1

Have periodic lab tests to assess your progress ( ) 5 ( ) 4 ( ) 3 ( ) 2 ( ) 1

Comments _____

_____

_____

_____