SKYLIMIT
Integrated Wellness Solutions

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Please complete the Medical History Evaluation form BEFORE your first appointment. Please remember to bring your completed form with you at your first appointment. ***If you do not bring your completed Medical History Evaluation Form, we will have to reschedule the appointment to another date and time.***

You may fax, email, or bring it to the office ahead of time, but please a paper copy with you at the time of visit.

You also may want to bring:

1) Current prescriptions for hormones
2) Current supplements you are taking and also any previous lab results that you have had done in the past 6 months as well.

SKYLIMIT WELLNESS INTEGRATED WELLNESS SOLUTIONS

FEMALE MEDICAL HISTORY EVALUATION FORM

Today's date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____ Cell phone: _____

City: _____ State: _____ Zip Code: _____Home phone:_____

Email address: _____ Do you regularly check email? ___Yes ___No

Height: _____ Weight: _____ Occupation _____

Primary Care Physician/Provider:
Name: _____
Address: _____
Phone: _____Fax: _____

Alternate doctor:
Name: _____
Address: _____
Phone: _____Fax: _____

		How often and how much?
Do you use tobacco?	____Yes ____ No	_____
Do you use alcohol?	____Yes ____ No	_____
Do you use caffeine?	____Yes ____ No	_____
Do you exercise regularly?	____Yes ____ No	_____

Describe typical meals.
Breakfast - _____
Lunch - _____
Dinner - _____
Snacks - _____

Allergies: Please list all that apply.
Drugs: _____
Foods: _____
Other: _____
Please describe the allergic reaction when it occurred: _____
_____
_____

Medical Conditions/Diseases: Please check all that apply to you.

____ Heart disease	____ High cholesterol	____ High blood pressure	____ Cancer
____ Ulcers	____ Thyroid disease	____ Hormonal related issues	____ Lung conditions
____ Blood clotting problems	____ Diabetes	____ Arthritis/joint problems	____ Depression
____ Epilepsy	____ Headaches/migraines	____ Eye disease	____ Bipolar disorder
____ Chronic Fatigue Syndrome	____ Lyme disease	____ Schizophrenia	____ Infection: please list
____ Parkinson's disease	____ Irritable Bowel Syndrome	____ Traumatic Brain Injury	____ Fibromyalgia
____ Colitis	____ Fractures	____ Eating Disorder	____ Osteoporosis
____ Kidney trouble	____ Other: please list		

GYN/OB

How many pregnancies have you had? ____ How many children? _____ Ages: _____
Any interrupted pregnancies? _____ If yes, when: _____
Are you currently trying to get pregnant? _____ Yes _____ No
Have you had a hysterectomy? _____ If yes, when: _____ Ovaries removed? _____
Have you had a tubal ligation (tubes tied)? _____ If yes, when: _____
Have you had an endometrial/uterus ablation? _____ If yes, when: _____

Have you had any of the following tests performed?

Mammography	_____	Date: _____	Outcome: _____
PAP smear	_____	Date: _____	Outcome: _____
Bone Density	_____	Date: _____	Outcome: _____
Thyroid Panel	_____	Date: _____	Outcome: _____

At what age did your periods begin? _____
Since then, have you ever had what YOU would consider to be abnormal cycles? _____
If yes, please tell when and what symptoms you experienced? _____
_____
_____

When was your last period? _____ How many days did it last? _____
Are you sexually active? _____ Current birth control method (if applicable) _____
Do you have Premenstrual Syndrome (PMS)? _____ If yes, please explain symptoms:
_____
_____

Please list all **Over-The-Counter (OTC)** items you currently or occasionally use, such as antacids, pain relievers, acid blockers, laxatives, antihistamines, decongestants, cough suppressants, anti-diarrheals, sleep aids, etc. -
Do NOT include Nutritional Supplements
_____
_____
_____

Nutritional/Natural Supplements: Please identify and list the products you are using:
Vitamins (examples: multiple or single vitamins such as B complex, E, C, etc.)_____
_____
Minerals (examples: calcium, magnesium, chromium, etc.)
_____
_____
Herbs (examples: Ginseng, ginkgo biloba, etc.) _____
_____
Enzymes (examples: digestive formulas, CoEnzyme Q10, etc.)_____
_____
Nutrition/Protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.) _____
_____
Other: _____
_____

Current Hormone Therapies:

Name	Strength	Date Started	How often per day

List hormones previously taken:

Name	Strength (if known)	Date Started	Date Stopped	Reason for stopping

Current Prescriptions Medications:

Name	Strength	Date started	How often per day

Have you ever used contraceptives? _____ Any problems? _____ If yes, please describe:

_____

_____

_____

_____

Do you have a family history of any of the following?

_____ Uterine Cancer Family member(s) _____

_____ Ovarian Cancer Family member(s) _____

_____ Fibrocystic Breast Family member(s) _____

_____ Breast Cancer Family member(s) _____

_____ Heart Disease Family member(s) _____

_____ Thyroid Disease Family member (s) _____

_____ Diabetes Family member(s) _____

_____ Osteoporosis Family member (s) _____

_____ Alzheimer's Family member(s) _____

Please write down any questions you have about Bio-identical Hormone Replacement (BHRT).

_____

_____

Adrenal Questionnaire

I have not felt well since

_____when_____
(Date) (Describe event, if any)

Predisposing Factors: Check you severity level: 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe

_____ I have experienced long periods of stress that have affected my well-being.
_____ I have had one or more severely stressful events that have affected my well-being
_____ I have driven myself to exhaustion
_____ I overwork with little play or relaxation for extended periods
_____ I have taken long term or intense steroid therapy
_____ I tend to gain weight, especially around the middle (spare tire)
_____ I have a history of alcoholism &/ or drug abuse
_____ I have environmental sensitivities
_____ I have diabetes (type II, adult onset, NIDDM)
_____ I suffer from post-traumatic distress syndrome
_____ I suffer from anorexia
_____ I have one or more other chronic illnesses or diseases

Energy Patterns

_____ I often have to force myself in order to keep going. Everything seems like a chore.
_____ I rely on caffeine and/or sugar to get through the day.
_____ I am easily fatigued
_____ I have difficulty getting up in the morning (don't really wake up until about 10 am)
_____ I suddenly run out of energy
_____ I usually feel much better and fully awake after the noon meal
_____ I often have an afternoon low between 3:00 – 5:00 PM
_____ I get low energy, moody, or foggy if I do not eat regularly
_____ I usually feel my best after 6:00 PM
_____ I am often tired at 9:00 – 10:00 PM, but resist going to bed
_____ I like to sleep late in the morning
_____ My best, most refreshing sleep often comes between 7:00 – 9:00 AM
_____ I often do my best work late at night (early in the morning)
_____ If I don't go to bed by 11:00 PM, I get a second burst of energy which often last until 1:00 – 2:00 AM

Thyroid Evaluation Form

Please indicate your severity level: **0 = None, 1 = Mild, 2 = Moderate, 3 = Severe**

SYMPTOMS

_____ Depression
_____ Dizziness
_____ Inability to lose weight
_____ Goiter (Enlarged thyroid)
_____ Cold Extremities
_____ Hoarseness
_____ Cold Intolerance
_____ Dry eyes
_____ Sleep disturbances
_____ Slow pulse rate
_____ Dry Hair
_____ Rapid heartbeat
_____ Hair loss
_____ Heart palpitations
_____ Brittle Hair/Nail
_____Puffy Eyelids/Face
_____ Dry Skin
_____ Acne
_____ Eczema
_____ Foggy Thinking/Forgetfulness
_____ Difficult Menses
_____ Elevated cholesterol
_____ Fatigue
_____ Constipation

When did these symptoms start?

_____

Is there a family history of ANY thyroid disease? Please list whom and what type (goiter, hypothyroidism, Graves' Disease, Hashimoto's Disease, etc.)

_____
_____

Symptom Survey

Instructions: Please enter the appropriate response number to each question in the columns below.

0 = None/Absent 1 = Mild or Rare 2 = Moderate 3 = Severe

Add an * (asterisk) if symptom is intermittent or "comes & goes".

_____ Vaginal Dryness
_____ Incontinence
_____ Poor memory/concentration
_____ Bone loss
_____ Dry skin/eyes
_____ Heart palpitations
_____ Tearful/Weepy
_____ Urinary Tract Infections

_____ High blood pressure/cholesterol
_____ Irregular Menses
_____ Depression
_____ Anxiety
_____ Low Libido
_____ Hot flashes/night sweats
_____ Headaches

_____ Loss of muscle tone
_____ Decreased stamina
_____ Bone loss
_____ Fatigue
_____ Incontinence
_____ Lack of motivation
_____ Aches and pain
_____ Thinning skin
_____ Lack of sex drive

_____ Hair loss
_____ Uterine Fibroids
_____ Water retention
_____ Tender breast
_____ Fibrocystic breast
_____ Fibroids
_____ Weight gain
_____ Allergies/Sinusitis
_____ PMS
_____ Bone loss
_____ Sleep disturbances
_____ Mood Swings
_____ Heavy bleeding/clots/painful cycles
_____ Irregular cycles

_____ Ovarian cysts
_____ Pain in nipples
_____ Mid -cycle pain
_____ Facial hair
_____ Scalp hair loss
_____ Insulin resistance
_____ Aggression/Irritability
_____ Excess body hair
_____ Acne/oily skin
_____ Increased facial or body hair

_____ Stress
_____ Morning Fatigue
_____ Evening Fatigue
_____ Sugar cravings
_____ Low blood pressure
_____ Arthritis/aches/pain
_____ Blood sugar imbalances
_____ Decreased immune system
_____ Fibromyalgia
_____ Allergies

_____ Insomnia/sleep disturbances
_____ Tired but wired feeling
_____ Blood sugar imbalances
_____ Overwhelmed
_____ Elevated triglycerides
_____ Irritable
_____ Panic attacks
_____ ADD/ADHD
_____ Compulsions/Addictions

Other: _____

What are you top 3 biggest concerns/symptoms?

1. _____
2. _____
3. _____