Cunningham Clinic

Getting Started Health Assessment- Female

Name:_____ Date:_____

Phone Number:_____ Email:_____

DOB:_____ Height:_____ Weight:_____ Address:_____

Allergies if any:

_____

_____

Surgical history if any:

_____

_____

Supplements/Medications currently taking and doses:

_____

_____

_____

How many grams of protein do you consume daily?:

_____

Symptom Review: Please check the symptoms that you're experiencing	Not applicable	Moderate	Severe
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	◯	◯	◯
Sleep Problems (difficulty falling asleep or sleeping through the night)	◯	◯	◯
Hot Flashes (burst that starts in chest and lasts for short duration)	◯	◯	◯
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	◯	◯	◯
Difficulties with memory (concentration, finding the right word, or retaining information)	◯	◯	◯
Vaginal dryness or difficulty with sexual intercourse or painful intercourse	◯	◯	◯
Sexual problems (change in desire, activity, orgasm and/or satisfaction)	◯	◯	◯
Sweating (night sweats or increased episodes of sweating)	◯	◯	◯
Hair Loss, Thinning or change in texture of hair	◯	◯	◯
Feeling cold all the time, having cold hands or feet	◯	◯	◯
Bladder Problems (difficulty in urinating, increased need to urinate, incontinence)	◯	◯	◯
Weight (difficulty losing weight despite diet/exercise)	◯	◯	◯
Breast tenderness	◯	◯	◯
Brittle nails	◯	◯	◯
Dry or flaky skin	◯	◯	◯
Decrease muscle mass	◯	◯	◯

Patient Questions

Date of last mammogram (was it normal or abnormal?):

_____

Date of last PAP (was it normal or abnormal?):

_____

Date of last Pelvic Ultrasound (was it normal or abnormal?):

_____

Date of last Colonoscopy (was it normal or abnormal?):

_____

Currently Pregnant or Trying to Conceive: ◯ Yes ◯ No

Date of last Physical (was it normal or abnormal?):

_____

Date of last menstrual cycle: _____

Have you had a hysterectomy? ◯ Yes ◯ No

Are you on birth control? ◯ Yes ◯ No

If you answered yes, indicate i the following:

◯ **Complete (uterus and ovaries removed)**

If yes, name of birth control: _____

◯ **Partial (uterus only removed)**

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Getting Started Health Assessment- Female

Are you currently utilizing BHRT or HRT? ◯ Yes ◯ No

If you answered yes, what type of hormones (Testosterone, Progesterone, Estrogen or Thyroid), list dose of hormones:

_____

Patient Questions	Yes	No
Do you smoke?	◯	◯
Are you currently on oral nitrates?	◯	◯
Are you taking a statin?	◯	◯
Have you had an endometrial ablation?	◯	◯

Medical History:

Cardiovascular Conditions:

- ◯ Heart Attack or Stroke (within last 6 months)
- ◯ Hyperlipidemia
- ◯ Atrial Fibrillation
- ◯ DVT or Blood Clot (within last 6 months)
- ◯ Obstructive Sleep Apnea
- ◯ Hypertension
- ◯ Tachycardia

Gynecological Conditions:

- ◯ Pre-Menstrual Syndrome
- ◯ Fibroids or History of Fibroids
- ◯ Fibrocystic Breast Disease
- ◯ Polyps of History of Endometrial Polyps
- ◯ Endometriosis or Hystory of Endometriosis

Cancer:

- ◯ Breast Cancer
- ◯ Overian Cancer
- ◯ Meningioma
- ◯ Endometrial Cancer
- ◯ Thyroid Cancer or History of Thyroid Cancer
- ◯ Cervical Cancer
- ◯ Other Cancers _____ _____

Neurological Conditions:

- ◯ Epilepsy or Seizure Disorder
- ◯ Depression/Anxiety

Endocrine and Metabolic:

- ◯ Hyperthyroid
- ◯ Diabetes Type 2 or Insulin Resistance
- ◯ Hypothyroid
- ◯ PCOS
- ◯ Multiple Endocrine Neoplasia Type-2

Autoimmune Conditions:

- ◯ Diabetes Type 1
- ◯ Hashimoto's Thyroiditis
- ◯ Graves' Disease
- ◯ Ulcerative Colitis
- ◯ Multiple Sclerosis
- ◯ Systemic Lupus (Erthematosus)
- ◯ Psoriasis
- ◯ Rheumatoid Arthritis
- ◯ IBS (Irritable Bowel Syndrome)
- ◯ Crohn's Disease

Organ Specific Conditions:

- ◯ Liver Disease or History of Liver Disease
- ◯ Hepatitis
- ◯ Hemochromatosis
- ◯ Kidney Disease or History of Kidney Disease
- ◯ LAM (Lymphangioleimyomatosis)
- ◯ HIV
- ◯ Pancreatitis or History of Pancreatitis
- ◯ History of or Gall Bladder Disease
- ◯ Osteoporosis or Osteopenia

Anything else you would like to discuss with your provider:

_____

_____

_____