Smith FACIAL PLASTICS

FUNCTIONAL MEDICINE HEALTH HISTORY FORM

Name: _____ DOB: _____

Please complete the following health history form. Please provide as much detail as possible to help me better understand your individual health needs and to help me provide the best care for you. This detailed form may take 30 minutes to complete. Please do not leave a section blank. Simply write 'none' or 'not applicable' if a question does not apply to you or if you do not have a response. I look forward to working with you soon!

Wendy F. Currier NP-C, RN, BS

What would you like to discuss at your appointment?

_____
_____
_____

How do your health conditions affect you day to day?

_____
_____
_____

Is there anything that you feel like triggered or contributed to your health concerns or symptoms?

_____
_____
_____

What have you tried previously that has been helpful or failed?

_____
_____
_____

Who is your primary care provider?

_____
_____
_____

Have you seen any other healthcare providers/specialists in the past five years?

_____
_____
_____

Please check the box(es) with your health goals:

- ☐ Further evaluation and guidance for your health conditions and symptoms
- ☐ Overall wellness and prevention of chronic disease
- ☐ Perimenopause or menopause guidance
- ☐ Hormone concerns
- ☐ Gut health evaluation
- ☐ Personalized supplement regimen

MEDICAL HISTORY

Please list any known allergies to medications, foods, or the environment. Please write 'none' if you are not allergic to anything.

_____
_____
_____

Please list medications and supplements. Please write 'none' if you are not taking any medications or supplements.

_____
_____
_____

Last measurements and date:
Weight-
Height-
Blood pressure-

Were you breastfeed?
Were you born prematurely?
Were there any complications when you were born?
Were you born by c section?

As far as you know, was your mom healthy during the pregnancy with you?
Have you used any of these medications frequently or on an ongoing basis during childhood or adulthood?

- ☐ Advil (ibuprofen), Aleve (naproxen), Aspirin
- ☐ Tylenol (acetaminophen)
- ☐ Acid- blocking drugs (otc or prescription)

Please list **ALL** of your health conditions/diagnoses below (during your childhood and adulthood). List everything that has ever affected you even if you feel it was minimal. Please disclose any illnesses, chronic diseases, cancer past or present, health events or accidents, or life stressors. Write 'none' if no medical history.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list all surgeries and hospitalizations below. Write NONE if no prior surgeries or hospitalizations.

_____
_____
_____
_____
_____
_____
_____
_____

Please list any significant dental history including mercury fillings, root canals, implants, teeth or gum issues.

_____
_____
_____

DIAGNOSTIC STUDIES (please list date and result)

- ☐ Bone Density:
- ☐ Upper Endoscopy/EGD:
- ☐ Colonoscopy:
- ☐ Mammogram:
- ☐ Pap Smear:
- ☐ Ultrasound:
- ☐ X-ray:
- ☐ CT scan:
- ☐ MRI:
- ☐ EKG:
- ☐ Cardiac Stress Test:
- ☐ Other:

SOCIAL HISTORY (how much and how often?)

- ☐ Alcohol:
- ☐ Cigarettes/cigars:
- ☐ Marijuana:
- ☐ Illegal Drugs:
- ☐ Other Substances:
- ☐ Have you ever felt you needed to cut back or reduce your intake?

FAMILY HISTORY

List your family members and all of their health diagnoses or health concerns. Please include the age if living. If deceased, please write their age at death and the cause of death.

Father:
Mother:
Paternal Grandmother:
Paternal Grandfather:
Maternal Grandmother:
Maternal Grandfather:
Sibling:
Sibling:
Sibling:
Adopted:
Other:

LIFESTYLE HISTORY

Sleep:
How many hours per night do you sleep on average?
Do you have trouble falling asleep? YES or NO
Do you have trouble staying asleep? YES or NO
Do you wake up feeling refreshed after sleeping? YES or NO
What interrupts your sleep?
Do you snore? YES or NO
Do you wake up gasping for air or has someone ever witnessed you holding your breath when sleeping? YES or NO
Do you take sleep aids (over the counter or prescription)? YES or NO
Do you mostly have a consistent bedtime and wake up time? YES or NO
Do you work 2nd or 3rd shift? YES or NO

Movement:
What do you do for exercise/movement currently? How many times per week and for how long?

_____

_____

Nutrition:
Do you currently follow any of the following special diets or nutritional programs?

- ☐ None- I eat whatever and whenever I want.
- ☐ Vegetarian
- ☐ Pescatarian
- ☐ Vegan
- ☐ Low Fat
- ☐ Low Carb
- ☐ High Protein
- ☐ Low Sodium
- ☐ Blood Type Diet
- ☐ Dairy Free
- ☐ Keto
- ☐ Gluten Free
- ☐ Intermittent Fasting

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

- ☐ Fast eater
- ☐ Eat too much
- ☐ Late night eating
- ☐ Dislike health foods
- ☐ Time constraints
- ☐ Travel frequently
- ☐ Eat more than 50% of meals away from home
- ☐ Healthy foods not easily available
- ☐ Poor snack choices
- ☐ Significant others or family members don’t like healthy foods
- ☐ Cravings that are hard to control
- ☐ Dietary needs for others around me
- ☐ Love to eat
- ☐ Eat because I have to
- ☐ Have negative relationship to food
- ☐ Struggle with eating issues (current or past)
- ☐ Emotional eater
- ☐ Eat too much under stress
- ☐ Eat too little under stress
- ☐ Don't care to cook
- ☐ Confused about nutrition advice

<u>Typical Food Intake</u>

Breakfast:

Lunch:

Dinner:

Snacks:

Water:

Soda/Juice:

Stress
Please rank your level of stress for each below on a scale 0 (no stress)-10 (max stress) or Not Applicable.

Job:
Kids:
Significant Other:
Friends:
Parents:
Finances:
Parents:
Finances:
Health:
Sex Life:
School:
Other:

Do you feel you have an excessive amount of stress in your life? YES or NO

Do you feel you can easily handle the stress in your life? YES or NO

Have you ever sought counseling? YES or NO

Are you in counseling now? YES or NO

Do you feel you have a good support system? YES or NO

Do you feel safe at home? YES or NO

What relaxation techniques do you use to manage your stress? YES or NO

Are your coping strategies working? YES or NO

What are your hobbies and leisure activities that you enjoy? Are you currently doing your hobbies?

ENVIRONMENTAL HISTORY

Please check the boxes if you are regularly exposed to any of the below at your home, workplace, or with your hobby.

- ☐ Mold
- ☐ Renovations
- ☐ Electromagnetic radiation (extended phone and computer use)
- ☐ Carpets or rugs
- ☐ Stagnant or stuffy air
- ☐ Pesticides (from food or yard treatments)
- ☐ Harsh chemicals
- ☐ Heavy metals (lead, mercury, etc)
- ☐ Airplane travel
- ☐ Water leaks
- ☐ Personal care products (makeup, soaps, shampoos) * check this box if you are not sure if you use products that are considered low toxic
- ☐ Damp environments
- ☐ Old paint
- ☐ Smoke (cigarette or wood burning)
- ☐ Cleaning chemicals
- ☐ Paints
- ☐ Other
- ☐ None
- ☐ Check this box if you read labs and check the ingredients in your food, cleaning products, and personal care products.

FEMALE SPECIFIC QUESTIONS

(skip to the next section if this does not apply to you)

- Who is your OBGYN/female health care provider?
- How old were you when you started your menstrual cycle?
- How often are your cycles occurring?
- List the first days of your last 3 cycles.
- Do you ever have to change your tampon/pad every hour on a heavy day?
- Do you have any concerns about your menstrual cycle?
- Do you have to adjust your schedule when on your cycle due to pain/bleeding?

- Are you on any hormones right now?

- If you still have menstrual cycles, do you feel your symptoms get better or worse at certain times during your cycle (during ovulation or right before your period)?

- How many pregnancies did you have?

- How many living children do you have? # Boys/girls?

- If you had children, did you experience any complications during or after pregnancy?

- Have you experienced any trauma around female health issues or with pregnancies/deliveries that I should be aware of?

- If you are struggling with infertility, please share details and treatment plan/specialist information up to this point in time.

Have you ever been diagnosed with or struggled with any of the following female conditions or concerns?

- ☐ Primary ovarian insufficiency
- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Pelvic inflammatory disease
- ☐ Uterine fibroids
- ☐ Fibrocystic breast disease
- ☐ Premenstrual syndrome (PMS)
- ☐ Premenstrual dysphoric disorder (PMDD)
- ☐ Polycystic ovarian syndrome (PCOS)
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Infertility
- ☐ Other
- ☐ None of the above

Tell me about your pregnancy outlook:

- ☐ I am actively trying to get pregnant for less than 1 year.
- ☐ I have been actively trying to get pregnant for more than 1 year.
- ☐ I am currently preventing pregnancy.
- ☐ I do not have a plan right now and am okay if I were to get pregnant.
- ☐ I do not have a plan right now and would like to discuss options.
- ☐ I am menopausal (no period for more than one year) so this does not apply.

What birth control methods have you ever used in your lifetime? Did you like or dislike the method? Did you experience any side effects with the method?

- ☐ I have never used birth control.
- ☐ Birth control pills
- ☐ Nuvaring or annovera ring
- ☐ IUD (copper)
- ☐ IUD (Mirena, Liletta, Skyla)
- ☐ Depo
- ☐ Uterine ablation
- ☐ Tubal ligation
- ☐ Condoms
- ☐ Partner had vasectomy

Have you had any of the following surgeries/procedures? List the reason and year.

- ☐ Both ovaries removed
- ☐ Uterus and cervix removed (ovaries remain)
- ☐ Uterus only removed (cervix and ovaries remain)
- ☐ Both ovaries and uterus removed
- ☐ Uterine ablation
- ☐ Tubal ligation
- ☐ Uterine artery embolization
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ I have all of my female parts.

Have you had any of the following conditions? Please list details if so.

- ☐ Estrogen receptor positive breast cancer
- ☐ Active liver disease
- ☐ Prior heart attack
- ☐ Prior stroke
- ☐ Prior hormone induced blood clot (from pregnancy or hormonal medication)
- ☐ Prior blood clot
- ☐ Unexplained vaginal bleeding
- ☐ High risk endometrial or ovarian cancer
- ☐ History of seizures
- ☐ Seizure disorder
- ☐ Peanut allergy
- ☐ Migraines
- ☐ Transient ischemic attack (TIA)
- ☐ Autoimmune Disease
- ☐ None of the above

Do you have a known genetic mutation?

- ☐ ATM, CHD1, CHEK2, NBN, NF1, SK11
- ☐ BRCA 1, BRCA2, PALB2, PTEN, TP53
- ☐ Leiden Factor 5
- ☐ Other
- ☐ None

If you are seeking hormone therapy for perimenopause or menopause, is it for (select all that apply):

- ☐ symptom relief
- ☐ prevention of health issues
- ☐ optimal health and wellness

What have you tried before for hormonal symptom relief if anything?

_____

_____

_____

If you are having bothersome symptoms, please list your top three symptoms that you would like to start with improving.

1. _____
2. _____
3. _____

Do you have anything in mind for what you want to try or what you want to avoid?

_____
_____
_____

Do you know how old the females in your family (mother, sister) were when their periods stopped?

_____

If your periods stopped for over one year, how old were you? What year?

_____

Have you ever had bleeding 12 months after your last menstrual cycle?

_____

Is there anything else you think I should know or that you would like to tell me so I can best help you? Please list anything that I did not ask such as other symptoms or other conditions or concerns that you have.

_____
_____
_____
_____
_____

Signs and Symptoms
Rate each of the following based upon your typical health for the past 14 days.

Point Scale:
0- Never or Rarely a Problem
1- Mild Problem
2- Moderate Problem
3- Moderate- Severe Problem
4- Severe Problem

____ Fatigue
____ Night sweats/ hot flashes
____ Sleep trouble
____ Weight struggles
____ Low appetite
____ Frequent headaches
____ Sinus issues
____ Voice changes
____ Chest pain or heart palpitations
____ Out of breath
____ Cough
____ Wheezing
____ Snoring
____ Abdominal bloating
____ Stomach pain
____ Blood in stool
____ Nausea
____ Vomiting
____ Diarrhea
____ Excess gas (belching or flatulence)
____ Heartburn/ reflux
____ Stool changes (mucus/floating stool)
____ Constipation
____ Leaking urine
____ Pain during urination or with wiping
____ Urinary urgency/frequency/hesitancy
____ Muscle cramps or joint aches
____ Joint redness or stiffness
____ Sad/low mood
____ Excessive worry
____ Difficulty remembering or concentrating
____ Hard to make choices

____ Speech changes
____ Lightheaded or dizzy
____ Irritable
____ Fainting
____ Tingling/numbness
____ Brain fog
____ Trouble with purpose or meaning in life
____ Tremor
____ Loss of scalp hair
____ Unwanted hair growth
____ Cystic acne
____ Hives/rashes/dry skin
____ Nail changes (pitting/cracks)
____ Heavy menses
____ Irregular menstrual cycles
____ Painful cycles
____ Long cycles (>35 days) or short cycles (<25 days)
____ Painful intercourse
____ Vaginal dryness
____ Vaginal discharge changes
____ Breast tenderness
____ Breast cysts/lumps
____ Spotting between or before your period
____ Excessive mood changes before your period
____ Low libido
____ Penile discharge
____ Testicular changes
____ Trouble starting or maintaining an erection
____ Other
____**TOTAL POINTS**

I certify that the preceding medical information is true and correct. It is my responsibility to inform Wendy F. Currier, NP-C, at Smith Facial Plastics of my current medical conditions and to update my health history with any changes. I understand I need to disclose all my health information in order to receive the best care and that this disclosure is completely confidential.

Patient Printed Name: _____
Patient Signature: _____
Date: _____