HEALTH HISTORY FOR WOMEN

Please mark the scales with an x and check any boxes indicating 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 fewer layers, etc.

COLD — NORMAL — HOT

- ○ Cold hands or feet
- ○ Chills
- ○ Cold "in the bones"
- ○ Areas of numbness

Thirst for cold / hot drinks
- ○ Thirst, no desire to drink
- ○ Absence of thirst
- ○ Excessive thirst

- ○ Night Sweats
- ○ Unusual Sweats
- ○ *When?* _____
- ○ *Where on body?* _____

- ○ Hot hands or feet
- ○ Hot flashes
- ○ Hot in the afternoon
- ○ Hot at night

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

DRY — NORMAL — OILY

- ○ Dry skin
- ○ Dry hair
- ○ Dry eyes
- ○ Dry, brittle nails

- ○ Dry mouth
- ○ Dry lips
- ○ Dry throat
- ○ Dry nose / nosebleeds

Where on body?
- ○ Edema/Swelling _____
- ○ Rashes _____
- ○ Itching _____
- ○ Dandruff _____

- ○ Oily skin
- ○ Oily hair
- ○ Acne
- ○ Weight gain / loss

DIGESTION

DIARRHEA — NORMAL — CONSTIPATION

BM frequency.: ___ *times every* ___ *day(s)*
Stools keep shape? ○Yes ○No
- ○ Alternating diarrhea and constipation?
- ○ Indigestion

- ○ Gas
- ○ Bloating
- ○ Belching
- ○ Poor appetite

- ○ Nausea / Vomiting
- ○ Bad breath
- ○ Heartburn
- ○ Excessive hunger

- ○ Dry stools
- ○ Difficulty passing stool
- ○ Tired after BM
- ○ Foul-smelling stools

ENERGY

LOW — NORMAL — HIGH

- ○ Sudden energy drop
  Time of day: _____ a.m. / p.m.
- ○ Energy drop after eating
- ○ Fatigue

- ○ Dependence on caffeine / stimulants
- ○ Wired / ungrounded feeling
- ○ Body / limbs feel heavy
- ○ Body / limbs feel weak

- ○ Shortness of breath
- ○ Heart palpitations
- ○ Blood pressure high / low
- ○ Bleed / Bruise easy

- ○ Hard to concentrate
- ○ Poor memory
- ○ Dizziness / lightheaded
- ○ Headaches ___ *times a* ___ *week*

SLEEP

Average no. hours per night: ____
- ○ Difficulty falling asleep
- ○ Wake ___ *times a night at* : *a.m. / p.m.*
- ○ Wake to urinate *(How often?* _____ *)*
- ○ Disturbing dreams
- ○ Restless sleep
- ○ Not rested upon waking

EMOTIONS

What emotion(s) dominate your experiences?
- ○ Anger
- ○ Irritablity
- ○ Anxiety
- ○ Worry
- ○ Obsessive thinking
- ○ Sadness
- ○ Grief
- ○ Depression
- ○ Joy
- ○ Fear
- ○ Timid / shy
- ○ Indecision

EYES, EARS, NOSE, THROAT

- ○ Poor vision
- ○ Night blindness
- ○ Red eyes
- ○ Itchy eyes
- ○ Spots in front of eyes
- ○ Sinus congestion
- ○ Phlegm *(color* _____ *)*
- ○ Poor hearing
- ○ Ringing in ears
- ○ Excess earwax
- ○ Sore throat
- ○ Dental problems
- ○ Mouth sores
- ○ Cough

MENSES

Age at first menses: _____
Length of full cycle: _____ days
Length of menses: _____ days
Last menses start date: ____/____
No. of pregnancies: _____
No. of births: ____ premature: ____
No. of terminated pregnancies: ____

- ○ Heavy periods
- ○ Light periods
- ○ Painful periods
- ○ Irregular periods
- ○ Changes in body/psyche prior to menstruation (PMS)
- ○ Cramps
  - ○ *Before bleeding*
  - ○ *First day*
  - ○ *During period*
- ○ Clots
- ○ Breast tenderness
- ○ Mood changes
- ○ Fatigue with menses
- ○ Digestive changes with menses
- ○ Midcycle spotting
- ○ Yeast infections
- ○ Birth control pill (hormonal)

MENOPAUSE

Age at last menses: _____
Year changes began: _____

Hot flashes: ___ *times a day*
Night sweats: ___ *times a week*

- ○ Vaginal dryness
- ○ Loss of sex drive