



LifeTime Health Center
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Dear Patient,

I have designed this questionnaire to learn more about you in order to assist you in achieving your optimum health. I believe that a woman's lifestyle, habits, work history and other characteristics are a vital part of the health assessment and your participation in this process will help me better evaluate your test results, risk factors and preventative needs. This information will be placed in a secure file and will NOT be shared with anyone including your insurance company or other entities requesting medical records. If you are uncomfortable answering any of the questions, please feel free to leave the answer blank.

Sincerely,

Rene' McCarty, PAC
Zana Elliott, FNP

Date: _____

Name: _____ DOB: _____

Allergies: _____

Medications (Include prescriptions, non-prescriptions, herbs and supplements): _____

Childhood Diseases: _____

Transition Test

1. I have inherited negative attitudes about menstruation and menopause from my culture or family. Agree _____ Disagree _____
2. I have internalized negative cultural ideas about the female body such as thinking of my period as a "rag" or "curse" and enjoyment of sexual activity as shameful.
Agree _____ Disagree _____
3. After my pregnancies, I had postpartum depression. Agree _____ Disagree _____
Not applicable _____
4. My childhood included abandonment, emotional, physical or sexual abuse.
Agree _____ Disagree _____ Unsure _____

5. I try to ignore messages from my body expressed thru symptoms of illness.

Agree_____ Disagree_____

6. I take care of everyone else and put myself last. Agree_____ Disagree_____

7. I feel selfish or guilty about taking time for myself. Agree_____ Disagree_____

8. I am not following my life's purpose in my relationships and work.

Agree_____ Disagree_____

9. I feel that I have no special gifts, strengths, talents or accomplishment.

Agree_____ Disagree_____

Reproductive Health

I developed breasts at age_____, pubic hair at age_____, started periods at age_____.

Are you currently using contraceptives? What kind:_____

Are you currently trying to get pregnant?_____

First Pregnancy: Age_____ Prenatal Care?_____ Describe course and outcome; Miscarriage, abortion, vaginal birth or C-section, live birth:_____

Second Pregnancy: Age:_____ Prenatal Care?_____ Describe Pregnancy:_____

Third Pregnancy: Age_____ Prenatal Care?_____ Describe pregnancy:_____

Other Pregnancies:_____

Did you adopt a child or care for a non-biological child during your reproductive years?

Infertility Treatments?_____

My menstrual periods are: Regular (occurring every 28-32 days)_____ or Irregular (describe)_____

Days of flow per period_____ Flow is: light_____ moderate_____ heavy_____

My periods stopped at age_____

Describe symptoms during the week of your period: (headaches, backaches, cramping, fatigue, etc.)_____

Have you ever had cysts of the ovaries?_____

Have you ever had cancer of the female organs?_____

Have you ever had abnormal Pap smears?_____ Describe treatment and the diagnosis:_____

When was your last pap smear?_____

Have you ever had problems with the uterus such as abnormal bleeding or fibroids?____

Have you had a hysterectomy?_____ Do you still your ovaries?_____

When did you have it?_____

Have you had problems with the vulva or vagina?_____

Breast Health

Do you perform self breast exam?_____ How often?_____

Did you breast feed your children? _____ How long?_____

Do you have breast pain, tenderness or discharge?_____

Have you ever had a mammogram or ultrasound of the breast?_____

Date of last physical exam?_____ Date of last mammogram?_____

Have you ever had a breast biopsy?_____

Have you ever been diagnosed with breast cancer?_____ Describe diagnosis and treatment:_____

Have you ever had breast reduction or augmentation (implants)?_____

Sexuality

Are you sexually active?_____ Do you have intercourse?_____

Do you practice safe sex?_____ Are you in a long term relationship?____ How Long?____

Have you ever been diagnosed with a sexually transmitted disease?_____

Have you ever been raped or molested?_____

Did you report it?_____

Do you have any sexual concerns to discuss?_____

Premenstrual Syndrome Questionnaire

Please complete if you are concerned about this condition.

Have you noticed that you experience the following symptoms beginning about 2 weeks before your period each month, with a decrease in symptoms when your bleeding begins?

Mood Changes:

1. Anxiety (feeling of worry, panic out of proportion to usual worries)? Yes__ No__
2. Tearfulness (crying more often or easily)? Yes__ No__
3. Irritability (more short with coworkers, spouse or children)? Yes__ No__
4. Mood swings (angry, sad, happy, anxious)? Yes__ No__
5. Tension (feeling more nervous and tense at work and home)? Yes__ No__
6. Depressed (feeling down, sad, blue)? Yes__ No__

Behavior Changes:

1. Outbursts of anger and rage Yes__ No__
2. Impulsive acts (acting or speaking without thinking of consequences)? Yes__ No__
3. Fatigue (lack of energy, excessive tiredness)? Yes__ No__
4. Craving for sweets or chocolate? Yes__ No__
5. Craving for bread or alcohol? Yes__ No__
6. Craving for salty food? Yes__ No__

Body Changes:

- | | |
|------------------------------------|------------|
| 1. Weight gain? | Yes__ No__ |
| 2. Breast tenderness? | Yes__ No__ |
| 3. Bloating? | Yes__ No__ |
| 4. Constipation? | Yes__ No__ |
| 5. Dizziness? | Yes__ No__ |
| 6. Low back pain, joint pain? | Yes__ No__ |
| 7. Headaches? | Yes__ No__ |
| 8. Heart pounding, beating harder? | Yes__ No__ |
| 9. Swelling of hands and feet? | Yes__ No__ |

Brain Changes:

- | | |
|--|------------|
| 1. Change in appetite? | Yes__ No__ |
| 2. Poor sleep, restless, not restorative? | Yes__ No__ |
| 3. Change in coordination? | Yes__ No__ |
| 4. Change in sex interest? | Yes__ No__ |
| 5. Forgetfulness? | Yes__ No__ |
| 6. Difficulty in concentrating, staying focused? | Yes__ No__ |
| 7. Difficulty in decision making? | Yes__ No__ |
| 8. Memory problems? | Yes__ No__ |

Menopause or Perimenopause

Please complete if you are concerned about these conditions.

Mood Changes:

- | | |
|--------------------------------------|--------------------------------|
| 1. Anxious, overly worried, panicky? | Frequent__ Occasional__ Rare__ |
| 2. Irritable, hypersensitive? | Frequent__ Occasional__ Rare__ |
| 3. Depressed, unhappy? | Frequent__ Occasional__ Rare__ |
| 4. Anger outbursts? | Frequent__ Occasional__ Rare__ |

Behavior changes:

- | | |
|--------------------------------|--------------------------------|
| 1. Feeling unusually fatigued? | Frequent__ Occasional__ Rare__ |
| 2. Tiredness of mind and body? | Frequent__ Occasional__ Rare__ |

Body Changes:

- | | |
|---|--------------------------------|
| 1. Loss of luster to skin, hair, nails? | Frequent__ Occasional__ Rare__ |
| 2. Dryness of skin, vagina | Frequent__ Occasional__ Rare__ |
| 3. Hot flushes or flashes? | Frequent__ Occasional__ Rare__ |
| 4. Sweats, followed by being chilled? | Frequent__ Occasional__ Rare__ |
| 5. Pain or aches in joints or muscles? | Frequent__ Occasional__ Rare__ |
| 6. Headaches? | Frequent__ Occasional__ Rare__ |
| 7. Pounding heartbeat or flutters? | Frequent__ Occasional__ Rare__ |
| 8. Skin sensations of crawling insects? | Frequent__ Occasional__ Rare__ |
| 9. Dizziness? | Frequent__ Occasional__ Rare__ |
| 10. Vaginal burning or itching? | Frequent__ Occasional__ Rare__ |

- | | |
|---------------------------------------|--------------------------------|
| 11. Pain with urination? | Frequent__ Occasional__ Rare__ |
| 12. Increased frequency of urination? | Frequent__ Occasional__ Rare__ |
| 13. Leaking of urine? | Frequent__ Occasional__ Rare__ |
| 14. Increased urge to urinate? | Frequent__ Occasional__ Rare__ |
| 15. Scalp hair loss? | Yes__ No__ |
| 16. Sexual interest? | Normal__ Decreased__ |
| 17. Orgasm? | Normal__ Decreased__ |
| 18. Pain with sex? | Yes__ No__ |

Brain Changes:

- | | |
|---|--------------------------------|
| 1. Poor sleep, frequent awakenings, poor quality? | Yes__ No__ |
| 2. Decreased concentration? | Frequent__ Occasional__ Rare__ |
| 3. Forgetfulness? | Frequent__ Occasional__ Rare__ |
| 4. Memory problems (word, names)? | Frequent__ Occasional__ Rare__ |
| 5. "Foggy thinking", thoughts muddled? | Frequent__ Occasional__ Rare__ |
| 6. Sensations of numbness or tingling | Frequent__ Occasional__ Rare__ |

Cardiovascular Health

- Do you have any heart valve problems? _____
- Do you have high blood pressure? _____
- Have you ever had cardiac tests such as a stress test, thallium test, echocardiogram, catheterization, or Holter Monitor? _____
- _____
- Have you ever been diagnosed with a heart attack? _____
- Have you ever been diagnosed with heart failure or heart rhythm problems? _____
- _____
- Have you ever had your blood cholesterol measured? _____
- Are you currently experiencing any chest discomfort or unusual sensations? _____
- Describe _____
- Have you ever had a blood clot of the leg, arm, or lung? _____
- Other cardiovascular concerns? _____

Musculoskeletal Health

- Have you ever been diagnosed with a connective tissue, joint, bone or muscle disease? _____
- _____
- Have you ever fractured or chipped a bone, or torn ligaments requiring medical care? _____
- _____
- Have you ever had a bone density test? _____
- Results? _____
- Do you have trouble sleeping due to joint or muscle pain? Yes__ No__
- Do you experience joint or muscle pain on a daily basis? Yes__ No__
- Where do you feel joint or muscle pain? _____
- Do you experience redness, swelling or heat in the joints? Describe _____
- _____
- Do you take over-the-counter or prescription pain medicine? Yes__ No__
- What and how much? _____

Have you reduced or limited activities due to pain? _____
What makes your pain worse? _____
Do you experience stiffness in the morning? Yes___ No___
Has your pain made you depressed? Yes___ No___

Digestive and Nutritional Health

Have you ever been diagnosed with an illness of the liver, gall bladder, esophagus, pancreas or intestines? _____
Have you ever had testing of the digestive tract such as ultrasound, X-Ray, colonoscopy or sigmoidoscopy? _____
Have you had surgeries of the digestive organs? _____
Do you have difficulty swallowing liquids or foods? _____
Do you have indigestion or reflux? _____
Do you experience abdominal pain or bloating after meals? _____
How often do you have a bowel movement? _____
Do you have hemorrhoids or fissures? _____
Do you take laxatives? Describe: _____
Do you take over the counter medications or herbs for digestive symptoms? _____
Describe: _____
Any other digestive concerns? _____
Are you satisfied with your current body weight? Yes___ No___
Do you feel fat most of the time? Yes___ No___
Do you avoid letting your spouse see you without clothes? Yes___ No___
Do friends and family tell you that you are too thin? Yes___ No___
Do you restrict the amount of food you eat daily to control your weight? Yes___ No___
Do you use laxatives or diuretics to control your weight? Yes___ No___
Are you preoccupied with your weight? Yes___ No___
Do you exercise to keep your weight down? Yes___ No___
Have you made yourself vomit to keep from gaining weight? Yes___ No___
Have you had weight fluctuations of more than 10 lbs due to binging and fasting? Yes___ No___
Do you buy food secretly and consume it secretly? Yes___ No___
Do you feel ashamed about your eating habits? Yes___ No___
Do you end eating binges by falling asleep, vomiting or laxative use? Yes___ No___
Describe your typical diet and food choices:
Breakfast: _____
Lunch _____
Dinner _____
Snacks _____
Caffeine intake _____ Carbonated beverages _____

Respiratory Health

Have you ever been diagnosed with a lung disease? _____
Do you regularly experience shortness of breath or wheezing? _____
Are you bothered by cough? _____

Have you ever had a chest X-Ray? _____ When? _____

Skin Health

Please describe any "yes" answers.

Have you ever had skin lesions removed? _____

Do you wear sun screen? _____

During childhood or adolescence did you sun bathe or sunburn? _____

Have you had laser treatments to your face? _____

Do you bruise easily? _____

Do you experience dryness or wrinkling of the skin? _____

Do you have dark spots on the face or arms? _____

Any changes in your hair or nails? _____

Any chronic rashes? _____

Describe your skin care routine and use of cosmetics _____

Stress Scale

Please answer and score each answer as directed.

___ Give yourself 10 pts if you feel you have a supportive family member near you.

___ Give yourself 10 pts if you actively pursue a hobby. What is it? _____

___ Give yourself 10 pts if you belong to a social group or activity group outside of your family that meets at least monthly. What group? _____

___ Give yourself 15 pts if you are within five pounds of your ideal body weight for your height and bone structure.

___ Give yourself 15 pts if you practice some form of "deep relaxation" at least three times a week (meditation, prayer, yoga, imagery).

___ Give yourself 15 pts for each time you exercise 30 mins or more during the week.

___ Give yourself 5 points for each nutritionally balanced meal you consume on an average day.

___ Give yourself 5 pts if you do something that you enjoy that is just for your pleasure each week.

___ Give yourself 10 pts if you have someplace in your home that you can relax and be alone.

___ Give yourself 10 pts if you practice time management techniques in your daily life.

___ Subtract 10 pts for each pack of cigarettes you smoke in an average day.

___ Subtract 5 pts for each evening in the course of an average week that you take any form of medication, chemicals or alcohol to help you sleep.

___ Subtract 10 pts for each day during the course of an average day that you consume any form of medication, chemical substance or alcohol to reduce your anxiety or help calm you down.

___ Subtract 5 pts for each evening during the course of an average week that you bring work home.

___ Subtract 5 pts for each day during the course of an average week that you overeat or binge to cope with feelings of anger, anxiety or depression.

_____ Total Score. (Maximum 115)

Neurological Health

Have you ever been diagnosed with meningitis, brain tumor, head injury, stroke, seizures or other neurological disorders? _____

Do you have problems with slurred speech or balance difficulties? _____

Do you have a tremor or involuntary shaking of the hands or head? _____

Have you ever had tests such as a spinal tap, MRI, EEG or CT scan? _____

Have you noticed a significant change in your memory (getting lost, unable to balance a checkbook, confusion about dates)? _____

Headache Questionnaire

Please complete if headaches are a problem for you.

Describe location and type of headache pain: _____

Do foods or chemicals cause your headaches? _____

Are headaches connected to the menstrual cycle? _____

What time of the day do headaches occur? _____

How frequently do headaches occur? _____

How long do headaches last? _____

What relieves the headaches? _____

How long have you been experiencing headaches? _____

With the headache, do you experience sensitivity to light, loud noise or smells? _____

Does stress worsen your headaches? _____

What sort of medical treatment have you received for headaches? _____

Are headaches associated with numbness or weakness of the arms, legs or face? _____

Do you have changes in vision associated with headaches? _____

Do you take over the counter medicine for headache? How Much? _____

Well-Being Assessment

From Screaming to be Heard, by E. Vliet, M.D.

Describe an experience in which you had the feeling of being totally alive. _____

What makes you feel that life is really worth living? _____

What are 5 things that you like about yourself? _____

What are 5 things that you feel you do well? _____

List 5 things in your life you are happy with and do not want to change. _____

What are 5 things you are not happy with and want to change? _____

Which of the things in the previous list are in your control and which are not in your control? _____

Do you feel that you contribute positively to the lives of others? How? _____

What are 5 ways you can improve or maintain your well being without the assistance of others? _____

What are your most important aspirations? _____

What are some self-destructive or self-defeating behaviors that you want to stop? _____

What are several things that you tell yourself that you "should" do or "ought to" do that you really do not want to do? _____

Habits and Lifestyle

Who lives in your household? _____

Any pets? _____

Describe your neighborhood and living environment. _____

Do you feel safe in your house and relationships? _____

Where (region/city) did you spend most of your childhood? _____

Adulthood? _____

How many hours do you sleep at night? _____

Do you smoke cigarettes? How much? _____

Have you ever stopped smoking? Describe: _____

Do you drink alcohol to excess or use mood altering drugs more than 3-4 times a year? _____

In the past year, have you failed to do your work or take responsibility due to drinking too much alcohol or drug use? _____

Have you needed to use alcohol other drugs in the morning to 'get you going'? _____

Do you feel remorse after using alcohol or other mood altering drugs? _____

How often in the past year have you been unable to remember what happened the night before because you had been drinking or using drugs? _____

Have you or someone else been injured as a result of your drinking or drug use? _____

Has a friend or family member asked you to cut down or stop drinking/using? _____

Have you ever experienced blackouts? _____

Do you have a home computer? _____
How many hours a day do you use your computer? _____
What percent of time for: Correspondence _____ Shopping _____ Education _____
Entertainment/Leisure _____ Other (describe) _____
Do you feel that you spend too much time using your computer? _____
How many hours of television do you watch a day? _____

Occupational Health

What is your current occupation or occupation prior to retirement? _____
Describe your education. _____
Describe your work or volunteer environment. _____
How many hours a week do you work or volunteer? _____
Are you satisfied with your work or volunteer situation? _____
Have you served in the Armed Services? Describe. _____

If you are experiencing physical symptoms, please answer the following questions:

Do you have a condition that has failed to respond to standard treatment or is of unknown cause? _____
Are your symptoms different at home and work? _____
Are you currently, or have you been in the past exposed to chemicals, viruses, radiation, noise, repetitive work, or unusual stress in the work environment? _____
Are any of your co-workers experiencing similar symptoms? _____

Safety Assessment

Do you wear a seat belt all the time? _____
Are you trained in CPR? _____
Do you have a home first aid kit? _____
Do you have smoke detectors in your home? _____
do you have fire extinguishers in your home? _____
Do you keep guns unloaded and locked away? _____

Travel Assessment

Have you traveled overseas? Where and when? _____
Have you ever been diagnosed with a tropical illness? _____
Have you received vaccines or medications for foreign travel? _____

Spiritual Travel

What in your life gives you internal support? _____
What are your sources of hope, strength, comfort and serenity? _____
What sustains you during difficult times? _____
Do you consider yourself a part of an organized religion? _____

What aspects of your religion are helpful and not so helpful to you? _____

Has being ill or your current state of health affected your ability to follow your spiritual practice? _____

As a health care provider, is there anything I can do to help you in this area? _____

Are you worried about any conflicts between your beliefs and your medical care or medical decisions made by your providers? _____

Are there any practices or restrictions I should know about as your healthcare provider? _____

Have you made plans for end of life care? _____

Depression Scale

Please answer if you feel you have symptoms of depression.

	Absent	Mild	Moderate	Severe
Depressed mood, sad, feeling down				
Guilt feelings				
Thoughts of suicide				
Insomnia				
Lack of motivation				
Avoidance of people or social situations				
Lack of enjoyment in usual activities				
Tearful				
Irritable, short tempered				
Feelings of guilt or negative self thoughts				
Low energy				
Poor concentration				
Loss of appetite				
Increase in appetite				
Change in weight				
Feelings of wanting to 'run away'				
Thoughts of death or dying				
Suicidal thoughts				

Intrusive or unwelcome thoughts				
Feelings of hopelessness				

Patient-related Anxiety Scale (David W. Sheehan, MD, *The Anxiety Disease*)

The following is a list of problems and complaints that people sometimes have. Circle the number to the right that best describes how much that problem bothered you during the last 6 months.

0- Not at all 1- A little bit 2- Moderately 3- Markedly 4- Extremely

How much did you suffer from:

Lightheadedness, faintness or dizzy spells.	0	1	2	3	4
Sensation of rubbery, weak or "jelly leg".	0	1	2	3	4
Feeling off balance or unsteady.	0	1	2	3	4
Difficulty in getting breath, smothering sensation or rapid breathing.	0	1	2	3	4
Skipping or racing of the heart.	0	1	2	3	4
Chest pain or pressure.	0	1	2	3	4
Choking sensation or lump in the throat.	0	1	2	3	4
Tingling or numbness in parts of the body.	0	1	2	3	4
Anxiety episodes that build up as you anticipate some activity.	0	1	2	3	4
Hot flashes or cold chills.	0	1	2	3	4
Nausea or stomach problems.	0	1	2	3	4
Episodes of diarrhea.	0	1	2	3	4
Headaches or pains in the neck or head.	0	1	2	3	4
Feeling weak, tired or exhausted easily.	0	1	2	3	4
Spells of increased sensitivity to light, sound or touch.	0	1	2	3	4
Bouts of excessive sweating.	0	1	2	3	4
Feeling strange, foggy, unreal or detached.	0	1	2	3	4
Feeling you are outside or detached from your body.	0	1	2	3	4
Worrying about your health too much.	0	1	2	3	4
Feeling you are losing control or going insane.	0	1	2	3	4
Having a fear that you are dying or something terrible is about to happen.	0	1	2	3	4
Shaking or trembling.	0	1	2	3	4
Unexpected waves of depression.	0	1	2	3	4
Mood swings.	0	1	2	3	4
Being dependent on others.	0	1	2	3	4
Having to repeat the same action in ritual.	0	1	2	3	4
Intrusive, unwanted thoughts.	0	1	2	3	4
Difficulty falling asleep.	0	1	2	3	4
Awakening in the middle of the night or restless sleep.	0	1	2	3	4
Avoiding situations because they frighten you.	0	1	2	3	4
Tension and inability to relax.	0	1	2	3	4
Anxiety, nervousness, restlessness.	0	1	2	3	4
Sudden, unexpected spells or attacks.	0	1	2	3	4

Greene Climacteric Scale: For menopausal women only

	None	Mild	Moderate	Severe
Heart beating quickly and strongly				
Feeling tense or nervous				
Difficulty in sleeping				
Excitable				
Attacks of panic				
Difficulty in concentrating				
Feeling tired or lacking energy				
Loss of interest in most things				
Feeling depressed or unhappy				
Crying spells				
Irritable				
Feeling dizzy or faint				
Pressure or tightness in head or body				
Parts of body feeling numb or tingling				
Headaches				
Muscle or joint pain				
Loss of feeling in hands or feet				
Breathing difficulties				
Sweating at night				
Loss of interest in sex				

Conclusion

Is there anything else that you wish to share about your past or present health concerns? _____

