Integrative Gynecology Clinic
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Integrative Consultation Form

I look forward to our first visit together! Please find a quiet moment to complete this questionnaire before your appointment. I have carefully chosen these questions to address many aspects of your health, including mind, body and spirit. Your answers will help me to work with you in a way that best meets your health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so at your appointment.

Today's Date _____

First Name _____Preferred Name_____

Middle Initial _____Last Name _____

Date of Birth ___/___/___ E-mail Address_____

Phone Number Home (____) _____ Cell (____) _____Work (____) _____

Where can I leave a confidential message? (check one) ___Home ___Work ___Cell

Your preferred pronouns _____

Who referred you to my practice? _____

Birth order (Circle One) Only child, first, middle, or last

Please describe the **major expectations** that you have of your Integrative Consultation:
What are your health goals? What are your health concerns?

_____

_____

_____

_____

_____

_____

What health problems would you like us to address with your consultation? Please rank by priority:

1._____

2._____

3._____

Please list the name of **physicians and complementary medicine providers** who are part of your care team now or in the past:

Name	**Telephone # (optional)**	**Profession/Specialty**	**Dates of treatment From**	**To**

Please list the name of **psychiatrists, psychologists, counselors and psychotherapists** who are part of your care team now or in the past:

Name	**Telephone # (optional)**	**Profession/Specialty**	**Dates of treatment From**	**To**

Please list the name and diagnosis date of any current medical conditions.

_____

_____

_____

Please list the name and diagnosis date of any past or childhood medical conditions.

_____

_____

_____

Please list any diagnostic studies you have had done in the past, the date, and the result-
(CT, MRI, ultrasound, colonoscopy, EGD, EKG, Bone density scan, etc.)

_____

_____

_____

What **medications and remedies** are you currently taking? This includes over-the-counter medications, homeopathic and herbal remedies, and nutritional supplements. Use the back of this page if need to add more or attach a list.

Name	**Dose or quantity per day/ Brand or Manufacturer**	**When did you start it? Why?**

ALLERGIES

Are you allergic to or have you had a "bad reaction" to any medications or other substances? ____YES ____NO

If yes, please specify drug(s), substance(s) and type of reaction: _____

_____

Environmental allergies _____YES _____NO. If yes, please describe.

_____

_____

Food allergies _____YES _____NO. If yes, please describe.

_____

Exposure to toxic metals at job or home _____YES _____NO. If yes, please describe.

_____

Do you have dental amalgams (silver fillings) or root canals? _____YES _____NO

Please list number of times you have had antibiotics as a Child_____ Teen_____ Adult_____

Please list number of times you have taken oral/IM/IV steroids as a Child_____ Teen_____ Adult_____

Please list any **hospitalizations or surgeries** you have had:

Reason for hospitalization or surgery	**Date**

What **exercise activities** do you do in a typical week?

Activity Type	**Times per week**	**Minutes per time**

DIET

Do you skip meals? _____

Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian? Vegan? Gluten free?

_____

_____

What and how much do you drink on a typical day? (i.e.: water, caffeine drinks, soda, etc.)

_____

_____

How would you describe your relationship with food? _____

_____

_____

What **foods** do you eat on a regular basis?

Breakfast foods	
Lunch foods	
Dinner foods	
Foods you crave (sugar, chocolate, soda, coffee, etc.)	
Foods you dislike	
Snack foods	
Comfort foods	
Food allergies	

How many of your meals (including breakfast and lunch) each week are prepared in a restaurant? _____

Anything about your nutrition I should know?

_____

GUT

How often do you have a bowel movement? _____

Do you have any of the following? (please circle)
small stools, hard stools, diarrhea, loose stools, undigested food in stools, blood in stool, excessive gas, distended belly after eating, foods that make you have an urgent need to have a bowel movement? What foods?

_____

Have you had a colonoscopy and/or EGD? ____YES ____NO Date_____ Reason_____

ALCOHOL/BEVERAGE/RECREATIONAL INTAKE

Do you consume any of the following?

	Yes	No	If yes, how much per week	If quit, when
Beer or wine				
Liquor				
Tobacco products/ Vape				
Marijuana, cocaine or other drugs: (please specify)				
Coffee, coke or other drinks with caffeine (please specify)				

Do you feel that you have or had a problem with any of the substances listed above? _____YES _____NO

Have you ever had to cut down on your drinking? _____YES _____NO

Do you get annoyed when someone asks about your drinking? _____YES _____NO

Do you ever feel guilty about your drinking? _____YES _____NO

Do you ever make excuses for drinking or for your behavior while drinking? _____YES _____NO

SMOKING

Do you smoke? _____YES ____NO If yes, how long have you been smoking? _____

Have you smoked in the past? _____YES ____NO If yes, how long? _____

Do you have/have you had smoke exposure at home? _____ YES _____ NO

If yes, please explain: _____

_____

SLEEP

Overall do you feel that you get enough **sleep**? _____YES _____NO

What time do you go to bed? _____

What time do you wake up? _____

Do you wake up during the middle of the night? _____YES _____NO How often? _____ About what time? _____Are you able to go back to sleep?_____

Do you feel rested upon waking? _____YES _____NO

Do you take anything to help sleep? ____YES ____NO What do you take?_____

Do your screens (phone, TV, e-reader) have a bedtime before you? ____ YES ____ NO What time? _____

WOMEN'S HEALTH

Age of first menstrual period_____ Date of last menstrual period_____

Are your periods regular? _____YES _____NO

First day of most recent menstrual period? _____Usual Flow: _____Heavy _____ Moderate _____Light

Length of bleeding in days_____ Number of days between periods? _____

Do you have any of the following (please circle):
Painful Periods, Missed Periods, Spotting Between Periods, Excessive Vaginal Bleeding, Pain with intercourse, Bleeding after intercourse, Unusual Vaginal Discharge, Recurring Vaginal Infections, Low Libido, Vaginal dryness

If you have gone through menopause, have you had any post-menopausal bleeding? _____YES _____NO

Date of last: PAP/HPV Screen_____ Pelvic exam_____

Mammogram/Breast Imaging_____ Breast exam_____

History of abnormal mammogram? _____YES _____NO Date/Diagnosis_____

History of breast biopsy? _____YES _____NO Date/Diagnosis_____

Please list any Family members with Breast Cancer & age at diagnosis? _____

_____

Have you ever had an abnormal PAP? _____YES _____NO

If yes, when/treatment_____

Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Have you experienced complications during pregnancy/delivery/or post partum? _____YES _____NO

If yes, please explain. _____

_____

_____

Contraceptive History

Please circle the method of contraception you are currently using:

Birth Control Pills, Type _____Diaphragm/Cap _____

IUD, Type _____Nexplanon, Depo Provera, Condom and/or Foam, Suppository

Total Years of Use _____Date of Last Change _____

Tubal Ligation _____YES _____NO Hysterectomy _____YES _____NO

Partner with Vasectomy _____YES _____NO Other method_____

Problems with current method _____

_____

Have you used Contraceptive in the past? _____YES _____NO For how long?_____

What types? _____During what years?_____

Please list any history of sexually transmitted infections and date of diagnosis. _____

_____

_____

BIRTH HISTORY

Did your mother have a vaginal or cesarean section when you were born? _____Vaginal _____ Cesarean

_____I do not know

Were you born at term? _____YES _____NO _____ I do not know

If No, what gestational age were you born? _____

Were you breastfed? _____Yes _____ No _____ I do not know If Yes, for how long? _____

Have you experienced any traumatizing events in your life? _____

_____

_____

_____

What are the greatest sources of **stress** in your life? Describe activities or techniques you use to **relieve stress**.

_____

_____

_____

What are the greatest sources of **comfort** in your life? What brings you **joy** in your life?

_____

_____

_____

Who are the people, including members of your family, or animals **who play a very important role in your life?**

Name	Relationship to you	Age	Where do they live?

Who lives with you? _____

_____

Are you satisfied with your **personal relationships**? _____YES ____NO Please describe: _____

_____

_____

If you are a **parent**, do you have any concerns about parenting? _____YES _____NO
If yes, please describe:

_____

_____

Do you consider yourself heterosexual, homosexual, bisexual, transgender, other?

_____

Have you, or a close family member, ever experienced **emotional, physical, mental or sexual abuse or assault**? _____YES _____NO If yes, please explain: _____

_____

_____

Do you use any form of **birth control** or **protection from sexually transmitted infections**? ____YES ____NO
If yes, please describe:

_____

_____

Are you **sexually active**? _____ YES _____ NO With **men, women or both**?_____

Are you satisfied with your **sexual relationships**? _____YES ____NO
If no, please describe:

_____

_____

Do you belong to an **organized religion or spiritual group**? _____YES _____NO
Please describe your current religious or spiritual practice:

_____

_____

Are you currently a **student**? _____YES _____NO If yes, where? _____

How many **years of education** have you completed? _____

Do you have any **difficulties with learning**? _____YES _____NO
If yes, please describe: _____

_____
What is your **job or occupation? _____** How many hours a week do you work? _____

Are you satisfied with your **work**? _____YES _____NO

Please describe: _____

_____

_____

Is there anything about your **work that negatively affects your mental or physical health**?

_____

_____

_____

What is your current **annual household income**? (check one)
_____$20,000 _____$20,000-$40,000 _____$40,000-$60,000 _____$60,000-$80,000 _____$80,000-$100,000
_____$100,000-$200,000 _____>$200,000

Do you have any **concerns** about your current **FINANCIAL** situation? _____YES _____NO
If yes, please describe:

_____

_____

Do you have any **concerns** about your current **LIVING** situation? _____YES _____NO
If yes, please describe:

_____

_____

Is there **any other information** about you that you feel is important to tell me?

_____

_____

Please attach a **copy of a typical weekday and weekend schedule** for yourself. If you are unsure, track one day during the week and one on the weekend.

If you could do one thing in your life, name your **biggest dream, your life's mission**, what would it be?

Thank You,
Kristin Markell, MD, FACOG