Washington Regional Integrative Gynecology
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Integrative Gynecology Initial Annual 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 _____ Middle Initial _____ Last Name _____

Preferred 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?

_____

Who is your Primary Care Physician?

_____

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:

_____

_____

_____

Please list any **hospitalizations, procedures 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**

NUTRITION

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, painful bowel movements, 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_____ Result_____

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, soda 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_____

Are your periods regular? ☐ YES ☐ NO Number of days between periods_____

First day of most recent menstrual period? _____

Usual Flow: ☐ Heavy ☐ Moderate ☐ Light

Length of bleeding in days_____

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.
_____

_____

_____

Current Contraception-_____

Problems or concerns 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.

_____

_____

_____

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

_____

Are you **sexually active**? ☐ YES ☐ NO

With **men, women or both**?_____

Are you satisfied with your **sexual relationships**? ☐ YES ☐ NO
If no, please describe:

_____

_____

Have you experienced any traumatizing events in your life?

_____

_____

Have you, or a close family member, ever experienced **emotional, physical, mental or sexual abuse or assault**? ☐ YES ☐ NO If yes, please explain:

_____

_____

_____

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?

_____

_____

_____

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

_____

_____

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**?

_____

_____

_____

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?

_____

_____

_____

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

_____

_____

_____

Please check the health problems that apply to each family member	**Self**	**Grandparent**	**Father**	**Mother**	**Siblings**	**Child**
Alcoholism						
Allergies/Hay fever						
Anemia						
Arthritis/Rheumatism/Lupus						
Asthma						
Birth Defects						
Bleeding Disorders						
Cancer or Tumor						
Colitis or Crohn's						
Congenital Heart Disease						
Depression/Anxiety						
Diabetes						
Emphysema, COPD						
Epilepsy, Seizures						
Frequent Infections						
Genetic Disease						
Glaucoma, Cataracts, Macular Degeneration						
Gonorrhea/Chlamydia/Herpes/PID						
Gout						
Alzheimer's/Dementia/Parkinson's						
Heart Disease/Heart Attacks						
High Blood Pressure						
HIV, AIDS						
Infertility						
Kidney Disease						
Liver Disease, Hepatitis						
Mental Illness/Suicide (or attempted)						
Migraine Headaches						
Nervous Breakdown						
Obesity						
Osteoporosis						
Peptic Ulcer Disease						
Autoimmune Disease						
Prostate Problems						
Psoriasis, Eczema						
Rheumatic Fever						
Stroke						
Thyroid Disease						
Tuberculosis						
Other						

Please indicate symptoms of the multiple listed:	
Loss of Memory	
General Weakness, Loss of Energy, Fatigue	
Dizzy Spells, Fainting Spells or Blackouts	
Please indicate symptoms of the multiple listed:	
Frequent Headaches	
Vision Disturbances	
Hearing Loss, Ringing in Ears	
Ear pain or drainage	
Nosebleeds	
Sinus pains, Nasal Stuffiness	
Frequent Sore Throat, Tonsillitis	
Hoarseness	
Swollen Glands	
Shortness of Breath	
Frequent Coughs, Wheezing	
Palpitations, Chest Pains, Rapid Heartbeat	
Anxious Feeling in Chest or Stomach	
Poor Appetite	
Indigestion	
Abdominal Pain, Discomfort, Bloating, Nausea	
Constipation, Use of Laxatives	
Diarrhea, Bloody Stools	
Rectal Pain, Itching, Irritation	
Hemorrhoids, Anal Fissures	
Difficult Urinating	
Urinary Incontinence	
Burning with urination	
Frequent urination	
Breast pain or discharge	
Breast lumps	
Pain with intercourse, decreased libido	
Hot flashes, night sweats	
Irregular or painful periods	
Premenstrual tension/mood swings	
Vaginal Itch or odor	
Vaginal dryness	
Swollen or painful legs	
Back Pain, Sciatica	
Joint Pain, Joint Swelling	
Skin discoloration, rashes, sores, moles	
Severe perspiration, night sweats	
Nightmares, Recurrent Dreams	
Fears or Phobias	
Anxiety or Nervousness	
Angry, Irritable, Impatient, Critical	
Sadness, Grief, Depression	
Other	

Please expand on any checked boxes from above medical history:

_____

_____

_____

Thank you,

Kristin Markell, MD, FACOG