



Integrative Gynecology Clinic
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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 _____

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?

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?

Thank you,

Kristin Markell, MD, FACOG