BODY REJUVENATION

Functional Medicine Questionnaire – Female

General Information

Name _____ Age _____ Date of Birth _____

Current date _____ Email _____ Cell Phone _____

Mailing Address _____ City _____ State ___ Zip Code _____

Drug / Food Allergies _____

Current Health Issues and Medications

Disease	*Medications Name Milligrams*	*Dose*

Symptoms or Complaints:

Have you been diagnosed with Cancer: No___ Yes___ Type: _____

Treatment: _____

Smoking: Do you currently smoke? No___ Yes___ Packages per day____ Number of years ____

Women's history

Age at first period ____ Date of last menstrual period _____

Are you in menopause? □ Yes □ No If yes, age of last period: _____

Was menopause surgical? □ Yes □ No

If yes, explain the surgery: _____

Are you currently having symptomatic problems with menopause? (Check all that apply)

□ Hot flashes □ Mood changes □ Concentration / memory problems

□ Headaches □ Joint pain □ Vaginal dryness □ Weight gain □ Decreased libido

□ Loss of urine control □ Palpitations

Are you on hormone replacement therapy? □ Yes □ No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)

_____

Gynecological Exam / Procedures: (If applicable, indicate date)

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Last PAP smear: _____ □ Normal □ Abnormal
Last Mammogram: _____ □ Normal □ Abnormal
Last bone density: _____ □ Low □ High □ Within normal range

Other tests / procedures (type of list and dates): _____

Surgeries	Date	Complication

How well have things been for you? (Check on the scale from 1 to 10, or N / A if not applicable)

	N/A	Bad				Good					Very Good
In general	□	1	2	3	4	5	6	7	8	9	10
School	□	1	2	3	4	5	6	7	8	9	10
Work	□	1	2	3	4	5	6	7	8	9	10
Social life	□	1	2	3	4	5	6	7	8	9	10
With close friends	□	1	2	3	4	5	6	7	8	9	10
Sex	□	1	2	3	4	5	6	7	8	9	10
Attitude	□	1	2	3	4	5	6	7	8	9	10
With partner	□	1	2	3	4	5	6	7	8	9	10
With your children	□	1	2	3	4	5	6	7	8	9	10
With your parents	□	1	2	3	4	5	6	7	8	9	10

Family History:

Please check the family members who have or had any of the following conditions:

	Mother	Father	Brother(s)	Sister (s)	Child	Child	Child	Child	Maternal grandmot	Maternal grandfath	Paternal granmoth	Paternal grandfath	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	□	□	□	□	□	□	□	□	□	□	□	□	□
Heart Disease	□	□	□	□	□	□	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□	□	□	□	□	□	□
Obesity	□	□	□	□	□	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□	□	□	□	□	□
Thyroid disease	□	□	□	□	□	□	□	□	□	□	□	□	□
Demencia	□	□	□	□	□	□	□	□	□	□	□	□	□
Other(s): _____	□	□	□	□	□	□	□	□	□	□	□	□	□

Nutritional supplements (vitamins / minerals / herbs, etc.)

Name and Brand	Dose	Start date (month / year)	Reason for use

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