

# Optimal Women's Wellness



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## ***Consultation Evaluation***

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

E-mail address \_\_\_\_\_ Phone # \_\_\_\_\_

**What is the main issue that brought you here?**

Primary Physician \_\_\_\_\_ Health Insurance \_\_\_\_\_ HMO?PPO?

Last Paps \_\_\_\_\_ Last Blood Tests \_\_\_\_\_ Last Mammogram \_\_\_\_\_

**Social History** Married/Partnered? \_\_\_\_\_ How long? \_\_\_\_\_

Single? \_\_\_\_\_ Divorced? \_\_\_\_\_

Do you work? \_\_\_\_\_ How many hours/week? \_\_\_\_\_

Do you have kids living in household? \_\_\_\_\_ How old are they? \_\_\_\_\_

**On a scale of 1-5, One being low and 5 being high:**

Rate the quality of your life/marriage/work satisfaction \_\_\_\_\_

Rate the level of stress you feel you have in your life \_\_\_\_\_

**Medications/Supplements/Vitamins/Herbs** currently taking regularly

## ***Gynecological/Menstrual History***

How old were you when you started having periods?

Did/do you have frequent problems with irregular periods?

How many days did/does your period flow?

Were/are your periods heavy, medium or light in flow?

Did/do you ever require medical attention for very heavy bleeding?

Were you ever diagnosed with uterine fibroids?

Did you ever require medical attention for any other gynecological problem?

Did/do you have problems with menstrual cramping?

Did/do you have problems with headaches around the time of your period?

Did/do you experience PMS symptoms that affected your quality of life?

Did/do you have breast tenderness or lumpiness around your period time?

Did you ever have an abnormal PAPS that required treatment or surgery to restore the cells to normal?

Have you had surgery on your uterus, tubes, or ovaries? (If so, describe in surgical history section)

Did you ever have a breast lump that required biopsy or excision?

How many pregnancies have you had?                      How did you feel during your pregnancy(ies)?  
 How many deliveries have you had?  
 How many miscarriages have you had?  
 Have your periods stopped?                      If yes, when?  
 Did you ever take the birth control pill?                      If yes, for how many years?

## **Medical History**

Please **circle or highlight** any past or current medical problems you have/had:

*High Blood Pressure	*Colitis	*PMS
*High Cholesterol	*Irritable Bowel Syndrome	*Depression
*Heart Attack	*Diabetes	*Fibroid Tumors
*Angina	*Low Blood Sugar	*Osteoporosis
*Thyroid Imbalance (high or low)	*Liver Disease	*Fibromyalgia
*Anxiety	*Blood Clots	*Lupus
*Insomnia	*Cancer(what kind?)	*Arthritis
*Stomach Ulcers	*Migrane headaches	*Chronic Fatigue Syndrome
		*Endometriosis

## **Surgical History**

What surgeries have you had ?    Why did you have them?    What year?

## **Family History**

Has anyone in your immediate family had any of the following diseases? **Circle or highlight**

Heart disease (including heart attack and stroke before age 65)	Alzheimer's Disease
Thyroid disorder	Diabetes
Osteoporosis (thinning of the bones)	Macular Degeneration
Female cancers ( Ovarian, Uterine , Breast )	Other Cancers (please specify)
Mental illness	High Blood Pressure

## **Exercise Review**

Do you have a physical activity you enjoy to get in shape/lose weight?

If yes, how often do you do this activity?

For how many minutes?

If no, did you in the past?

What type of exercise(s)do you do?

## ***Dietary Review***

*How many times in the past 7 days did you consume the following foods: Put a number in front of each item: (Feel free to "guesstimate")*

- |  |   |
|--|---|
| <input type="text"/> <i>Soy based products</i>           | <input type="text"/> <i>Nuts/seeds</i>                        |
| <input type="text"/> <i>Peas/beans/lentils</i>           | <input type="text"/> <i>Fast foods</i>                        |
| <input type="text"/> <i>Cheese/yogurt/milk</i>           | <input type="text"/> <i>Red meat</i>                          |
| <input type="text"/> <i>Poultry or eggs</i>              | <input type="text"/> <i>Caffeinated beverages</i>             |
| <input type="text"/> <i>Fish/shellfish</i>               | <input type="text"/> <i>Alcoholic beverages</i>               |
| <input type="text"/> <i>Fresh or frozen fruits</i>       | <input type="text"/> <i>Cookies/chips/donuts/cakes/sweets</i> |
| <input type="text"/> <i>Fresh or frozen veggies</i>      | <input type="text"/> <i>Sodas (Diet? Regular?)</i>            |
| <input type="text"/> <i>Bread, pasta, potatoes, rice</i> |   |

## ***Cardiovascular Risk Assessment (circle the number if yes)***

1. *Has anyone in your immediate family had a heart attack or stroke before the age of 60?*
2. *Do you have high blood pressure?*
3. *Do you have elevated cholesterol?*
4. *Do you have diabetes?*
5. *Do you smoke?*      *If yes, how much and for how many years?*
6. *Are you overweight?*
7. *Do you have a sedentary lifestyle? (ie. Couch potato?)*

## ***Osteoporosis Risk Assessment (circle the number if yes)***

1. *Have you ever taken oral steroids for a medical condition?*
2. *Have you ever been treated for an overactive thyroid gland?*
3. *Do you drink on the average more than 2 alcoholic drinks daily?*
4. *Do you weigh less than 130 pounds?*
5. *Do you have a sedentary lifestyle?*
6. *Are you from northern European ancestry?*
7. *Do you have a history of missed periods prior to menopause?*
8. *Do you have a family history of broken bones in late life?*
9. *Is your diet lacking in dairy products for any reason?*
10. *Have you ever had your bone density tested?*  
*If so, what was the result?* \_\_\_\_\_

## ***Digestive Evaluation***

***Circle symptoms you are frequently bothered by:***

*heartburn   nausea   belching   gas   abdominal bloating   constipation*  
*diarrhea   intestinal cramping*

## Symptom Checklist

Answer the symptom questions by filling in the left hand column with one of the following:

**F for Frequently**

**S for Sometimes**

**N for Never/Not often**

- \_\_\_\_\_ Are you bothered by hot flashes or night sweats or both?
- \_\_\_\_\_ Do you often feel down/in a funk/unmotivated/"blah" when you didn't previously?
- \_\_\_\_\_ Do you find it difficult to fall asleep or do you wake frequently at night?
- \_\_\_\_\_ Do you feel more fatigued than you did previously?
- \_\_\_\_\_ Do you feel you have reduced stamina compared to previously?
- \_\_\_\_\_ Does your skin appear to have lost its "glow"?
- \_\_\_\_\_ Do your breasts appear to sag more or to have lost their fullness?
- \_\_\_\_\_ Do you experience vaginal dryness or pain with sexual activity?
- \_\_\_\_\_ Have you noticed a significant weight gain without a change in diet or activity?
- \_\_\_\_\_ At times do you feel bloated or that you are retaining fluid?
- \_\_\_\_\_ Have you had an increase in back or joint pains?
- \_\_\_\_\_ Have you had episodes of palpitations or racing of your heart?
- \_\_\_\_\_ Have you had an increase in frequency or intensity of headaches?
- \_\_\_\_\_ Does your abdomen feel or appear bloated?
- \_\_\_\_\_ Have you become more forgetful?
- \_\_\_\_\_ Do you feel like your mind is in a fog?
- \_\_\_\_\_ Is your mood low, less upbeat, less positive and less outgoing? Are you having less good moods and more down days? Do you find yourself caring less about things that used to matter to you? (answer if any of these apply)
- \_\_\_\_\_ Do you feel less receptive to sex? Do you feel less sensual? Do you feel your sex drive has diminished?

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- \_\_\_\_\_ Are you experiencing more anxiety/irritability?
  - \_\_\_\_\_ Has PMS been worse lately? (lasting longer or more severe?)
  - \_\_\_\_\_ Do you tend to spot a few days before your period is due to start?
  - \_\_\_\_\_ Are your breasts swollen and very tender before your period is due to start?

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- \_\_\_\_\_ Do you have less muscle strength? Decreased muscle tone?
  - \_\_\_\_\_ Do you feel less confident?
  - \_\_\_\_\_ Are you having more trouble remembering people and events?
  - \_\_\_\_\_ Do you have less energy and stamina when physically active?
  - \_\_\_\_\_ Are you less coordinated?
  - \_\_\_\_\_ Has your sex drive gone into the basement? Are you having fewer sexual fantasies?
  - \_\_\_\_\_ Are you noticing more wrinkles around your mouth and eyes? Is the skin tone on your arms, legs or hands poor?
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## ***Check the box if the statement applies to you***

- ☐ *I have experienced long periods of stress OR had a severely stressful event that has affected my well being*
- ☐ *I work more than I play & have little to no time for relaxation or fun*
- ☐ *I have been getting sick more frequently and they have been lasting longer than usual*
- ☐ *I have environmental sensitivities or allergies*
- ☐ *I am less productive at work*
- ☐ *I get lightheaded or dizzy when rising from a sitting or lying position*
- ☐ *I am fatigued in a way that is not relieved by sleep, I do not wake feeling refreshed*
- ☐ *I sometimes feel weak all over*
- ☐ *I am frequently cold or have decreased tolerance for cold*
- ☐ *I have less patience, a shorter temper, people irritate me more*
- ☐ *Everything seems like a chore*
- ☐ *I have difficulty getting up in the morning or don't wake up refreshed*
- ☐ *I feel worse if I skip a meal*
- ☐ *I have an increase in hair loss from my head*
- ☐ *I have constant stress in my life or work*
- ☐ *My food intake tends to be unplanned and sporadic*
- ☐ *My relationships at home &/or work are unhappy*
- ☐ *I feel overwhelmed by everyday things*
- ☐ *My life has lost all of its joy*
- ☐ *My ability to remain calm under pressure is gone*
- ☐ *I am unable to laugh at myself*
- ☐ *I have little control over how I spend my time. My life seems out of control*
- ☐ *I feel too exhausted on weekends and days off to do the things I enjoy*
- ☐ *I find myself isolating myself from others*
- ☐ *My mind is restless; I have a hard time turning it off when I try to relax*

**END OF EVALUATION**