PLEASE DON'T STAPLE

Corner Drugs, Inc.
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I charge ~~$95~~ (Currently Discounted at $55) for a complete evaluation. Go ahead and complete these questionnaires and get them back to me, I will give FREE basic information but I have to charge due to the time it takes to completely evaluate your symptoms. I will promise it will be worth your time and money for me to completely evaluate and explain my recommendations.
I would also like current labs and back as far as 3 years if possible. Request your health care practitioner fax them to 1-888-710-7228

MEDICAL HISTORY- FEMALE ♀

These questions may seem silly and unnecessary but there is a purpose to each and every one of them. If you want the best professional recommendation it is very important to answer every question.

Date: _____

Name _____ Birth Date _____ Age _____

Weight _____lb Weight 1 yr ago _____ Height_____

E-Mail Address : _____

Best phone # to reach you _____

Address _____

Occupation: _____

Education completed: _ Grade school _ High school _ College _ Graduate school

Marital status: ___Single _ Married ___Separated
___Divorced ___Widowed

Spouse/Partner's name: _____

Number of children: _____

Who lives at home with you?_____

Do you: Smoke? □Yes □No Packs per day _____ # Years smoked _____

Drink Alcohol? □Yes □No Drinks per day _____

Drink cola/coffee? □Yes □No How much per day? _____

How much *pure* water do you drink daily? _____

Do you use artificial sweeteners routinely? □Yes □No If so which ones ? _____

If you don't know the name, what color are the packets _____
Do you drink diet colas? _____

Do you exercise regularly? □Yes □No How many times per week? _____

What type of exercise? _____

Are you currently on a diet or havc you been on a diet within the last 2 years? □Yes □ No
what was the name of the diet? _____

What were your results? _____

List the medications/supplements & OTCs you are now taking or have taken within the last month:
Provide a separate list if needed.

_____

_____

List any allergies you have to drugs, food or other items:

_____

_____

When was your last bowel movement? _____

Do you have a BM at least every day? □Yes □No
If no, approximately how many BMs do you have in a week? _____

Please circle the consistency of your stool
Watery Loose Firm Pellets Soft

Are you allergic to soy? □Yes □No

Are you currently under medical care for any reasons? If yes, please explain:

_____

_____

(Circle all that Apply) Pregnant? Nursing? Taking Calcium?

Taking Hormones (HRT)? Oral Contraceptives/Birth Control

Primary Care Physician Name: _____

City & State: _____

Phone (if known): _____

List Operations/procedures you have had:

Operation Performed	Year	Hospital	Doctor/Surgeon

List all times you have been admitted to a hospital overnight (except for childbirth).

Reason Hospitalized	Year	Hospital	Doctor/Surgeon

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

□High blood pressure	□Kidney Disease	□Asthma
□Stroke	□Bleeding Tendencies:	□Tuberculosis
□Cancer	□Seizures	□Colitis
□Emphysema	□Heart Disease	□Anemia
□Ulcers	□Diabetes	□Gout
□Mental Illness		

Indicate how you are related if a family member is:
□Obesity □Extremely Obese

Other Illnesses not listed:_____

Do you take Coumadin/Warfarin/Plavix or Aspirin? □Yes □No

Immunizations current: □Yes □No

Sleep Patterns: Do you go to bed at a regular time most days (6 out of 7)? _____

What time do you go to bed? _____ What time do you wake? _____

Do you sleep through the night? _____

If you awake at night do you fall back to sleep easily? _____

Are you on the computer within 3 hours of time for bed?_____

How do you feel when you first wake up? _____

Do you hit the snooze multiple times? _____

Please explain any sleeping abnormalities _____

Have you had any of the following illnesses:

□Measles	□Diabetes	
□Rubella (German Measles)	□Goiter, Thyroid Disease	
□Malaria	□Bladder or Kidney Infection	□Typhoid
□Chickenpox	□Hives	□Tropical Diseases
□Mumps	□Allergies	□Hepatitis
□Whooping Cough	□Eczema	□Venereal Disease
□Scarlet Fever	□Mono	□Seizures
□Tonsillitis	□Rheumatic Fever	□Meningitis
□Diphtheria	□Poliomyelitis	□Ear Infections
□Asthma	□Pleurisy	□Heart Murmur
□Glaucoma	□Bronchitis	□High Blood Pressure
□Cancer	□Influenza	□Low Blood Pressure
□Angina Pectoris	□Tuberculosis	□Heart Attack
□Ulcer	□Phlebitis	□Kidney Stones

Other illnesses: (Please Explain):

Please list the date and results or comments (if known) of your last:

X-ray:_____

EKG: _____

Blood Count: _____

Date of last examination by a doctor: _____

Do you use an IUD? □Yes □No

Which one? □Nonhormonal copper IUD -ParaGard®
□Hormonal IUD - Mirena®

Have you in the past taken birth control or hormones in the past year? □Yes □No

If yes what did you take _____

What are you currently taking? _____

How long have you been taking/using this? _____

When was your last PAP smear _____

When was your last breast mammogram _____

Age when menstrual periods began _____

Are your periods regular? _____ How Often? ____

Do you still have a menstrual cycle? _____

If so how many days do your periods last? _____

Date of your last 1st day of cycle (first day of spotting/bleeding) _____

How many days during bleeding do you have "heavy" bleeding? _____

How old were you when you first gave birth? _____

How many times have you been pregnant? _____

How many children born alive? _____

To your knowledge were you born □Vaginally or □ C- Section?

Please remember over the last 3 days and list everything you have eaten or drank:

_____
_____
_____
_____
_____
_____

How did you hear about Corner Drugs? _____

If I could wave a magic wand over you, what 3 major symptoms would you like to see disappear?

1._____

2._____

3._____

Please list any additional information that I did not ask that you think I need to know.

Please answer all symptoms regardless if you don't think you have the medical conditions

Category 1: Basic Hormone Imbalance
Mark which of the following symptoms are troublesem and/or persist over time.

__ Hot Flashes	__Mood Swings (PMS)	__ Urinary Incontinence
__Night Sweats	__Heart Palpitations	__Cystic Ovaries
__Vaginal Dryness	__Acne	__Heavy Menses
__Foggy Thinking	__Weight Gain	__ Depressed Mood
__Irritability	__Headaches	__Fibrocystic Disease
__Headaches	__Thinning Skin	__Increased body/facial hair
__Uterine Fibroids	__Bone Loss	

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Category 2: Adrenal Hormone Imbalance
Mark which of the following symptoms are troublesem and/or persist over time.

__Aches & Pains	__Elevated Triglycerides	__Morning Fatigue	__Bone Loss
__Sleep Disturbances	__Depression	__Anxiety	__Infertility
__Nervousness	__Allergic Conditions	__Autoimmune Illness	
__Blood/Sugar Imbalance	__Chronic Fatigue	__Evening Fatigue	__Susceptibility to infections

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Mark which of the following symptoms are troublesem and/or persist over time.

__Aches & Pains	__Anxiety	__Brittle Nails	__Depression
__Dry Skin	__Cold Hands/Feet	__Headaches	__ Infertility
__Fatigue	__Foggy Thinking	__Weight Gain	__Felling Cold all the Time
__Heart Palpitations	__Low Libido	__Sleep Disturbances	__Inability to lose weight
__Constipation	__Thinning Hair	__High Cholesterol	__Menstrual Irregularities

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Mark which of the following symptoms are troublesem and/or persist over time

__Smoker	__Weight Gain	__Heart Disease or Family of heart disease
__High Blood Sugar	__Sugar Cravings	__Diabetes or Family of Diabetes
__High Blood Pressure	__Fatigue	__Waist Size greater than 35 inches
__Overweight or Obese	__Low Physical activity	

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