Dr. Barbara Jennings
Natural Health In Real Life

Dr. Barbara Jennings at Health Summit Wellness
126 W Harvard St., Suite 5, Fort Collins, CO 80525 • 970-377-9611
• drbarbarajennings@gmail.com

FEMALE HEALTH HISTORY AND NEUROTOXIC QUESTIONNAIRE

GENERAL INFORMATION

Name: Date:

Address _____ Phone # (h) _____ (c) _____

_____ Email Address _____

_____ Age _____ Date of Birth _____

Status ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live with ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

Education _____

Occupation _____ Hours per week _____ Retired ☐

Employer _____ Work Address _____

Height _____ Are you pregnant? Yes ____ No ____ Are you breastfeeding? Yes ____ No ____

Weight _____ Are you cyclic? Yes ____ No ____ Are you in Menopause? Yes ____ No ____

In case of emergency, who should we contact?

Name _____ Relationship _____

Address _____ Phone _____

COMPLAINTS/CONCERNS

Please list your chief symptoms in order of decreasing severity, starting with the worst one. Please note how long each symptom has been present.

Problem	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	Mild / moderate / severe
2.			
3.			
4.			
5.			
6.			
7.			

ALLERGIES

Medication/Supplement/Food	Reaction

IMMUNIZATION HISTORY

Have you received any vaccinations in the last 5 years? Yes ____ No ____ If yes, please list: _____

_____

DENTAL HISTORY

Do you currently have any amalgam, silver, metal, and/or gold fillings? Yes ____ No ____ If yes, how many? _____

If yes, please list which kinds: _____

How long have you had these fillings? _____

If you do not have any fillings in your mouth, have you had any fillings removed in the last 12 months? Yes ____ No ____

Have you had any dental work done in the last 12 months? Yes ____ No ____

MEDICATIONS AND SUPPLEMENTS

Medications: Please list any medications that you are currently taking or have taken in the last month, including antibiotics, non-prescription drugs, and prescription drugs.

Medication Name	Dosage

Supplements: List all vitamins, minerals and other nutritional supplements that you are currently taking.

Supplement Name/Brand	Dosage

Have your medications or supplements ever caused you unusual side effects or problems?

Yes _____ No _____ If yes, please describe: _____

SLEEP/REST

Average number of hours you sleep ☐ > 10 ☐ 8 – 10 ☐ 6 – 8 ☐ < 6

Do you have trouble falling asleep? Yes ____ No ____

Do you rested upon awakening? Yes ____ No ____

Do you have problems with insomnia? Yes ____ No ____

Do you snore? Yes ____ No ____ Explain: _____

LIFESTYLE INDICATORS

TOBACCO HISTORY

Currently using tobacco? Yes ____ No ____ How many years? _____ Packs per day: _____

If yes, what type? Cigarette _____ Smokeless _____ Cigar _____ Pipe _____ Patch/Gum _____

Previous smoking: How many years? _____ Packs per day: _____

Are you exposed to 2nd hand smoke? If yes, please explain: _____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 oz wine, 12oz beer, 1.5 oz spirits*

None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____ > 10 _____

Previous alcohol intake? Yes _____ (Mild _____ Moderate _____ High _____)

CAFFEINE INTAKE

How many cups of coffee per day? None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____

How many cans of soda per day? None _____ 1 – 3 _____ 4 – 6 _____ 7 – 10 _____

Is the soda you drink, diet soda? Yes _____ No _____

PREGNANCY HISTORY (Check box if yes and provide number of)

☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal deliveries _____

☐ Miscarriage _____ ☐ Abortion _____ ☐ Living children _____

☐ Post partum depression ☐ Toxemia ☐ Gestational diabetes

☐ Baby over 8 pounds ☐ Breastfeeding For how long? _____

FOR THE CYCLIC-AGE WOMAN

Age at 1st period: _____ Frequency: _____ Length of period: _____ Pain: Yes ____ No ____

Clotting: Yes ____ No ____ Has your period skipped? _____ For how long? _____

Last Menstrual Period: _____ How many days is your current cycle? _____

Do you currently use contraception? Yes _____ No _____ If yes, what type do you use?

☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Have you ever used hormonal contraception? Yes _____ No _____ If yes, when _____

Use of hormonal contraception: ☐ Birth control pills ☐ Patch/injection ☐ Nuva Ring

Are you using the pill now? Yes _____ No _____ Did taking the pill agree with you? Yes _____ No _____

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes _____ No _____

Date of last Mammogram _____ Breast Biopsy/Date _____

Last PAP Test _____ Normal _____ Abnormal _____

Other information for us to know: _____

FOR THE WOMAN IN MENOPAUSE

Age at onset of menopause: _____ Year of onset of menopause: _____

When you were cycling, would you consider your cycle regular? Yes ____ No ____

If no, why?: _____

When you were cycling, what was your typical menstrual flow? Light _____ Medium _____ Heavy _____

Have you had a hysterectomy? Complete (ovaries and uterus) _____ Partial (uterus only) _____

Date of hysterectomy _____ Reason for hysterectomy: _____

Date of last Mammogram _____ Breast Biopsy/Date _____

Date of last Bone Density _____ Results: ☐ High ☐ Low ☐ Within normal range

Are you in menopause? Yes _____ No _____ Age at Menopause _____

Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin ☐ Progesterone

☐ Provera ☐ Other _____

How long have you been on hormone replacement? _____

How did you hear about our Wellness and Nutrition Program?

_____

_____

_____

_____

_____

What is your major complaint and when did these symptoms begin?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.)

Is there anything in your medical history that you consider to be relevant?

What is your employment history? Please provide brief summary.

Please list all past surgeries and the condition each surgery was for.

Please explain your housing history (type of homes, where and when).

PATIENT HISTORY

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

MERCURY

☐ Yes ☐ No Do you have amalgam (silver) fillings in your teeth?

☐ Yes ☐ No Have you ever had them in the past?

☐ Yes ☐ No Did your mother have amalgam when pregnant with you?

☐ Yes ☐ No Have you ever worked in a dental office? If so, how long? _____

☐ Yes ☐ No Have you had any dental crowns, bridges, root canals, dry sockets or infected tooth extractions?

☐ Yes ☐ No Do you have any dental implants or other metal in your mouth?

☐ Yes ☐ No Did you wear contact lenses during the 1980's or early 1990's?

☐ Yes ☐ No Did you take oral contraceptives during the 1980's or early 1990's?

☐ Yes ☐ No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?

☐ Yes ☐ No Have you noticed any adverse reactions to these shots?

☐ Yes ☐ No Do you have any tattoos with red ink?

☐ Yes ☐ No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

LEAD

☐ Yes ☐ No Does your occupation involve soldering, metal salvage, old home repair or sandblasting?

☐ Yes ☐ No Was your home built before 1978?

☐ Yes ☐ No Have you ever worn cosmetics containing kohl?

GENERAL TOXICITY

☐ Yes ☐ No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.

_____

☐ Yes ☐ No Have you ever had any chemical exposures? (I.e. cleaning chemical spills, working in a beauty salon, etc.)

MOLD

How old is the house you are living in? _____ How long have you lived there? _____

☐ Yes ☐ No Do you see mold growing at home, work or school?

☐ Yes ☐ No Have you ever had water damage at home, work or school?

☐ Yes ☐ No Does your home, workplace or school have a damp or mildew smell?

☐ Yes ☐ No Does spending time in your basement cause of worsen your symptoms?

☐ Yes ☐ No Does your basement ever get wet?

☐ Yes ☐ No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?

LYME DISEASE

☐ Yes ☐ No Have you ever been diagnosed with Lyme Disease?

☐ Yes ☐ No Have you ever been bitten by a tick or recluse spider?

☐ Yes ☐ No Have you ever seen a bulls-eye rash appear on any part of your body?

☐ Yes ☐ No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?

☐ Yes ☐ No Was your mother ever diagnosed with Lyme Disease?

☐ Yes ☐ No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas?

HEALTH HISTORY

☐ Yes ☐ No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?

☐ Yes ☐ No Does anyone in your family experience similar symptoms to yours?

What is your birth order (i.e. first born, second, third, etc.)? _____

☐ Yes ☐ No Do you have any history of kidney dysfunction?

☐ Yes ☐ No Do you or any immediate family member have a history with cancer?

☐ Yes ☐ No Do you have any history of heart disease, myocardial infarction (heart attack), etc,?

☐ Yes ☐ No Are you currently having any thoughts of suicide?

☐ Yes ☐ No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?

☐ Yes ☐ No Do you have a history of strokes?

☐ Yes ☐ No Have you ever been diagnosed with diabetes mellitus?

☐ Yes ☐ No Have you ever been in an auto accident, fallen or received a major physical injury?

☐ Yes ☐ No Are you in menopause?

☐ Yes ☐ No Do you have any allergies to food or medications.

Name: _____ Date: _____

Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

Point Scale

0 = Never had the symptoms
1 = Occasionally have it, mild effect
2 = Occasionally have it, severe effect
3 = Frequently have it, mild effect
4 = Frequently have it, severe effect

	Anxiety
	Mood swings
	Enraged behavior or anger for no reason
	Excessive shyness, timidity, social phobia (not typical to your personality)
	Irritability (not typical to your personality)
	Low body temperature (below 97.5)
	Insomnia (can't get to sleep or return to sleep)
	Dizziness
	Sound in ears (ringing or hearing your heart beat)
	Psychological symptoms, even thoughts of suicide
	Sensitivity to sound
	Indecisiveness
	Feeling of being overwhelmed or fearful
	Metallic taste in your mouth
	Bad breath
	Bleeding gums
	Sensitive teeth
	Canker sores or other sores in the mouth
	Floaters, shadows or swimmers when you read or look into the sky
	Dyslexia or loss of place while reading, even as a child
	Swelling eyelids
	Peeling on top layer of skin (hands, feet)
	Dry skin
	Heart pain (angina) and you are under 45 years old
	Depression
	Gout (arthritic pain, especially in big toes_
	Pain in shoulders or upper back
	Twitching eyelids
	Anemia (low iron/hemoglobin on blood test)
	Wrist/ankle drop or weak extensor muscles
	Hair falls out (not normal male pattern baldness)
	Trouble processing new information

	Sensitivity to light
	Fatigue after exercising (feeling worse)
	Bad night vision or seeing halos around lights
	Shortness of breath, with very little effort
	Excessive thirst and/or frequent urination
	Red eyes or tearing
	Blurred vision at times
	Morning stiffness
	Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners
	Chronic fatigue or weakness
	Non-restful sleep
	Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.)
	Word reversal or trouble finding words
	Sensitivity to touch
	Short-term memory loss
	Chronic sinus congestion
	Dry-non productive cough
	Muscle twitching
	Excessive sweating, especially at night
	Joint pain - not necessarily true arthritis - can move from joint to joint
	Difficulty losing weight regardless of diet or exercise
	Persistent fungal or viral infection, including athlete's foot, warts, jock itch, candidiasis
	Frequent illness, prolonged illness or sick days
	Numbness or weakness in arms and legs
	Headaches
	Trouble adding or dividing numbers in your head
	Fluctuating constipation and diarrhea
	Stomach pain for no apparent reason
	Appetite swings
	Frequent muscle aches, cramps, unusual sharp sudden pains
	Rashes or rosacea
	Cold extremities