

MINSTER ACUPUNCTURE STUDIOS
HEALTH HISTORY FOR WOMEN

Please mark an X on the scales and check any boxes of symptoms you have had in the past month

TEMPERATURE

How warm / cold you feel (not in degrees); relative to other people do you wear more or less layers, etc.

COLD

HOT

- Cold hands or feet
- Chills
- Cold "in the bones"
- Areas of numbness

- Thirst for cold / hot drinks
- Thirst, no desire to drink
- Absence of thirst
- Excessive thirst

- Night sweats
- Unusual sweats
- When? _____ am / pm
- Where on body _____

- Hot hands, feet, chest
- Hot flashes
- Hot in afternoon
- Hot at night

MOISTURE

Your overall body moisture (hair, skin, mouth, bowels, etc.)

DRY

OILY

- Dry skin
- Dry hair
- Dry eyes
- Dry brittle nails

- Dry mouth
- Dry lips
- Dry throat
- Dry nose / Nosebleeds

- Edema / Swelling _____
- Rashes _____
- Itching _____
- Dandruff _____

- Oily skin
- Oily hair
- Pimples
- Weight gain / loss

Where on your body?

DIGESTION

DIARRHEA

CONSTIPATION

- BM: How often? _____ x / every _____ days
- Stools keep shape? Y N
- Alternating diarrhea & constipation (IBS)
- Indigestion

- Gas
- Bloating
- Belching
- Poor appetite

- Nausea / Vomiting
- Bad breath
- Heartburn
- Excessive hunger

- Dry Stools
- Difficult to pass
- Tired after BM
- Foul smelling stools

ENERGY

LOW

HIGH

- Sudden energy drop
- Time of day: _____ am / pm
- Energy drop after eating
- Fatigue

- Dependence on caffeine / stimulants
- Wired / ungrounded feeling
- Body / Limbs feel heavy
- Body / Limbs feel weak

- Shortness of breath
- Heart Palpitations
- Blood pressure High / Low
- Bleed / Bruise easy

- Hard to concentrate
- Poor memory
- Dizziness / lightheaded
- Headaches _____ x / week

SLEEP

- # hours per night _____
- Difficulty falling asleep
- Wake _____ y / night @ _____ am / pm
- Wake to urinate How often? _____
- Disturbing dreams
- Restless sleep
- Not rested upon waking

EMOTIONS

What emotion(s) dominate your experience?

- | | |
|---------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Joy |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Obsessive thinking | <input type="checkbox"/> Timid / shy |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Indecision |

EYES, EARS NOSE THROAT

- | | |
|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Excess earwax |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Dental problems |
| <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Phlegm (color _____) | <input type="checkbox"/> Cough |

MENSES

- Age at first menses: _____ days
- Length of full cycle: _____ days
- Length of menses: _____ days
- Last menses start date: _____ / _____
- # of pregnancies: _____
- # of births: _____ premature _____
- # of abortions / miscarriages: _____

MENOPAUSE

- | | | |
|-----------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------|
| Age at last menses: _____ | <input type="checkbox"/> Hot flashes _____ x / day | <input type="checkbox"/> Vaginal dryness |
| Year changes began: _____ | <input type="checkbox"/> Night sweats _____ x / week | <input type="checkbox"/> Loss of sex drive |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Light periods | <input type="checkbox"/> Cramps |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Before bleeding |
| <input type="checkbox"/> Changes in body/psyche prior to menstruation (PMS) | <input type="checkbox"/> Clots | <input type="checkbox"/> During period |
| <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Fatigue w/ menses |
| | <input type="checkbox"/> Digestive changes w/ menses | <input type="checkbox"/> Midcycle spotting |
| | <input type="checkbox"/> Yeast infections | <input type="checkbox"/> Birth control pill (hormonal) |