

IMPORTANT: BODY TEMPERATURE MEASUREMENT.

If time permits, Please take your body temperature using an oral thermometer on 5 separate mornings and record below. Do the measurement just after waking (prior to any food or drink). They do not need to be on consecutive mornings.

DAY 1 DAY 2 DAY 3 DAY 4 DAY 5

Current menstrual pattern (regular, irregular, heavy, light, etc.): _____

Menstrual period started at age: _____

Total number of pregnancies: _____ Number of live births: _____

Have you ever taken the oral contraception pill at any stage in your life? Yes No

Note approximate periods of times in your life you took the oral contraceptive pill:
(e.g. Age 14-25, pregnancy, no oral contraceptive pill until next pregnancy age 30, oral contraceptive pill 32 until now)

Have you had a hysterectomy? No Yes Date: _____

Have your ovaries been removed? No Yes Date: _____

When was your last breast check by a doctor? _____

When was your last mammogram? _____

Result of last mammogram: _____

When was your last pap smear test? _____

Result of last pap smear test: _____

Have you had a bone densitometry to check for Osteoporosis? No Yes Date: _____

Result of last densitometry: _____

List any surgical operations you have had in your life:

List any medical illnesses you have had in your life:

List any family history of illnesses, in particular breast cancer or blood clotting problems:

List any major stress events in your life (e.g. the death of someone close to you, divorce, etc):

What are your current work and life activities? (e.g. job, home activities, hobbies)

List any hormone replacement therapy you have had:

List any medications you are currently taking:

List any supplements you are currently taking:

List the things you do for exercise each week. (If your job is physically demanding include this too):

If you have been / are a current smoker please complete the following details

Began smoking: _____

Quit smoking between: _____ and _____

_____ and _____

_____ and _____

_____ and _____

Quit smoking successfully: _____

Still smoking? Please list the amount of cigarettes per day: _____

Fluid amounts per day

Coke / Pepsi / other caffeinated soft drinks: _____

Other soft drinks: _____

Milk: _____

Water: _____

Coffee: _____

Tea: _____

Alcohol: _____

Dietary History

State what are the most common things you would eat with each meal

Breakfast: _____

Mid morning: _____

Lunch: _____

Mid afternoon: _____

Dinner: _____

After Dinner: _____

Snacks: _____

Shade in all areas of pain - include headaches and any other pain anywhere in the body

