Note: this document is a form that you can fill out. Once filled out you can save it to your PC, then email it to admin@austin3dhealth.com. Please include your name in the filename when you save it to your PC.

Westlake Oaks Executive Park
1101 S Capital of Texas Hwy
Bldg. K, Ste. 100
Austin, Texas 78746
Phone: 512-915-1999
Fax: 855-915-1900

PLEASE PRINT

PERSONAL INFORMATION

NAME _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ e-Mail Addr: _____ DATE OF BIRTH _____

MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____

EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

REFERRED BY _____

FEMALE HEALTH HISTORY QUESTIONNAIRE

Weight: _____ Height: _____ Occupation: _____

What is the reason for this visit?

_____

_____

_____

List medications you are currently taking:

_____

_____

Any known drug allergies?

_____

List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

_____

_____

List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

List significant non-GYN health issues (diabetes, surgeries, etc.):

Date of last pelvic/gynecological exam: Last Pap Test: Last mammogram:

Last thermography? Unusual results?

Are you currently under another physician's care?

Do you eat sugar/refined carbs? Yes No How much/how often?

Do you drink alcohol? Yes ☐ No ☐ How much/how often?

Do you smoke? Yes ☐ No ☐ How much/how often?

How often do you exercise? never ☐ rarely ☐ sometimes ☐ regularly ☐ competitively. ☐

SIGNS & SYMPTOMS	ONGOING	JUST W/ PERIOD	MILD	MODERATE	SEVERE	MORE INFORMATION
Mood swings						
Anxiety/Nervousness						
Overly Reactive/Short fuse						
Irritability						
Depression						
Lowered self-esteem/self-image						
Caretake others before yourself						
Sadness/Crying						
Foggy thinking						
Memory difficulties						
Fatigue						
Constant hunger						
Sweet cravings (carbs/chocolate)						
Hypoglycemia						
Hyperglycemia (diabetes)						
Weight gain						
Weight loss						
Water Retention						
Bloating						
Irritable Bowel						
Constipation						
Light colored stool						
Loose stool/Diarrhea						
Nausea/vomiting						
Headaches/Migraines						
Body/Joint Aches						
Back Ache						
Acne						
Excessive facial hair						
Body/Head hair loss						
Dry skin/Brown spots						
Lowered Libido						
Heightened Libido						
Hot flashes						
Night sweats						
Breast tenderness/swelling						
Nipple discharge						
Vaginal infections						
Urinary frequency						
Incontinence						
Vaginal dryness						
Painful intercourse						

Any other symptoms? _____

REPRODUCTIVE HEALTH HISTORY *(please fill in or check the appropriate answer)*

Age at onset of menarche (first period): _____ Approximate date of onset: _____

Are you currently using a method of birth control? Yes ☐ No ☐

If yes, what method? _____

Are you, or have you used *(please circle)* oral, injected, patch, or ring hormone contraceptives? Yes ☐ No ☐

When and for how long? _____

Have you ever used Emergency Contraception (aka "the day after pill")? Yes ☐ No ☐ Year: _____

Any unusual reactions? _____

Are you, or have you used an IUD? Yes ☐ No ☐ If yes, when and for how long? _____

What type of IUD did you use? copper hormone other _____

Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue depression, palpitations, etc.)

_____

_____

_____

Have you used, or are you currently using fertility or treatment? Yes ☐ No ☐

If yes, please explain. _____

Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes ☐ No ☐ If yes, please explain: _____

_____

Have you been pregnant before? Yes ☐ No ☐ Age(s) of children: _____

Number of pregnancies? _____ Details/ Complications: _____

Number of live births: _____

Miscarriages: _____

Premature births: _____

Cesarean births: _____

Stillbirths: _____

Abortions: _____

Ectopic pregnancies _____

If you have had a miscarriage, how many weeks pregnant were you? _____

_____

Did you breastfeed? Yes ☐ No ☐ How long? _____

Have you had an abnormal Pap Test? Yes ☐ No ☐ Diagnosis/Reason: _____

Treatment and/or Medication: _____

Have you had a vaginal infection? Yes ☐ No ☐ If yes, what? _____

Treatment and/or Medication: _____

Any history of… Ovarian cysts? Yes ☐ No ☐ Uterine fibroids? Yes ☐ No ☐

Fibrocystic Breasts? Yes ☐ No ☐ Endometriosis? Yes No

Polycystic Ovarian Syndrome (PCOS)? Yes ☐ No ☐

FOR CYCLING-AGE WOMEN *(please fill in or check the appropriate answer)*

First day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes☐ No☐When? _____

Has there been any recent change in your cycle or symptoms associated with your cycle? Yes☐ No☐

If yes, please give details. _____

How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)

<20 _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____

How many days does menstruation typically last? _____

Is your cycle regular? Yes No Not Always Details: _____

Typical menstrual flow: Light Medium Heavy Details: _____

How many *pads* and/or *tampons* (circle) are used on heavy days? _____

Do you pass clots? Yes☐ No☐ How often? _____

Do you spot? Yes☐ No☐ At what point in your cycle? _____

Do you experience cramping? None Mild Moderate Severe None

At what point in your cycle? _____

Do you experience abnormal vaginal discharge? Yes☐ No☐ If yes, when? _____

Do you experience vaginal itching and/or odor? Yes☐ No☐If yes, when? _____

Do you experience breast tenderness? None Mild Moderate Severe None

At what point in your cycle? _____ Change in breast size? Yes No

Do experience nipple discharge? Yes☐ No☐ If yes, when? _____

What color? _____

FOR MENOPAUSAL WOMEN *(please fill in or circle the appropriate answer)*

Your age at the onset of menopause: _____ Year of onset: _____

Have you had a hysterectomy? complete *(ovaries AND uterus)* partial *(uterus only)* No

Date of hysterectomy: _____ Reason for hysterectomy: _____

Describe your experience transitioning into menopause *(symptoms, strong emotions, thoughts, unusual stressors, etc.)*

MENOPAUSAL WOMEN, CONT'D

Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes ☐ No ☐

If yes, what were you prescribed? _____

What dosage? _____ For how long? _____

Have you used, or are you currently using, bioidentical hormone creams/gels/sublingual, troche, oral, other? Yes ☐ No ☐

If yes, what? _____

What dosage? _____ For how long? _____

Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes ☐ No ☐

If yes, what? _____

What dosage? _____ For how long? _____

Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes ☐ No ☐

If yes, when? _____ Were you evaluate and/or treated by a GYN? Yes ☐ No ☐

Treatment: _____

PLEASE DESCRIBE YOUR CYCLE HISTORY.

How would you have described your menstruation? _____

Easy Uncomfortable Difficult Debilitating

What was your typical menstrual flow? Light ☐ Medium ☐ Heavy ☐

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

If no, explain. _____

Please describe any 'treatment' you ever received for cycle issues. _____

SLEEP HABITS

How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? _____

How many hours do you sleep a night on average? _____

Do night sweats wake you up? Yes No How often? _____

Do you wake up tired? Yes No How long has this been happening? _____

Is your room completely dark when you sleep at night? *(no night light, street lamp, TV, etc.)* Yes ☐ No ☐

Do you get at least 30 minutes of outside daylight time, several days each week? Yes ☐ No ☐

SYMPTOM SURVEY FORM

Reset Form

Patient _____ **Doctor** _____ **Date** _____

Birth Date ___/___/___ **Approx Weight** _____

Pulse: Recumbent _____ **Standing** _____

Blood Pressure: Recumbent: _____ **Standing** _____

Sex: Male ○ Female ○

Vegetarian: Yes ☐ No ☐

Ragland's Test is Positive _____

INSTRUCTIONS: Fill in only the circles which apply to you.

⊙ ○ ○	MILD symptoms (occurred once or twice last 6 months).
○ ⊙ ○	MODERATE symptoms (occurred once or twice last month).
○ ○ ⊙	SEVERE symptoms (chronic, occurred once or twice last week).

Leave circles BLANK if they don't apply to you!

	1 2 3		1 2 3	
		Group 1		**GROUP 4**
1	○ ○ ○	Acid foods upset	56 ○ ○ ○	Hands and feet go to sleep easily, numbness
2	○ ○ ○	Get chilled often	57 ○ ○ ○	Sigh frequently, "air hunger"
3	○ ○ ○	Lump in throat	58 ○ ○ ○	Aware of "breathing heavily"
4	○ ○ ○	Dry mouth-eyes-nose	59 ○ ○ ○	High altitude discomfort
5	○ ○ ○	Pulse speeds after meal	60 ○ ○ ○	Opens windows in closed rooms
6	○ ○ ○	Keyed up – fail to calm	61 ○ ○ ○	Susceptible to colds and fevers
7	○ ○ ○	Cut heals slowly	62 ○ ○ ○	Afternoon "yawner"
8	○ ○ ○	Gag easily	63 ○ ○ ○	Get "drowsy" often
9	○ ○ ○	Unable to relax; startles easily	64 ○ ○ ○	Swollen ankles, worse at night
10	○ ○ ○	Extremities cold, clammy	65 ○ ○ ○	Muscle cramps, worse during exercise; get "charley
11	○ ○ ○	Strong light irritates	66 ○ ○ ○	Shortness of breath on exertion
12	○ ○ ○	Urine amount reduced	67 ○ ○ ○	Dull pain in chest or radiating into left arm, worse on
13	○ ○ ○	Heart pounds after retiring	68 ○ ○ ○	Bruise easily, "black and blue" spots
14	○ ○ ○	Nervous stomach	69 ○ ○ ○	Tendency to anemia
15	○ ○ ○	Appetite reduced	70 ○ ○ ○	"Nose bleeds" frequent
16	○ ○ ○	Cold sweats often	71 ○ ○ ○	Noises in head, or "ringing in ears"
17	○ ○ ○	Fever easily raised	72 ○ ○ ○	Tension under the breastbone, or feeling of "tightness",
18	○ ○ ○	Neuralgia-like pains		
19	○ ○ ○	Staring, blinks little		**GROUP 5**
20	○ ○ ○	Sour stomach often	73 ○ ○ ○	Dizziness
			74 ○ ○ ○	Dry skin
		Group 2	75 ○ ○ ○	Burning feet
21	○ ○ ○	Joint stiffness on arising	76 ○ ○ ○	Blurred vision
22	○ ○ ○	Muscle-leg-toe cramps at night	77 ○ ○ ○	Itching skin and feet
23	○ ○ ○	Butterfly" stomach, cramps	78 ○ ○ ○	Excessive falling hair
24	○ ○ ○	Eyes or nose watery	79 ○ ○ ○	Frequent skin rashes
25	○ ○ ○	Eyes blink often	80 ○ ○ ○	Bitter, metallic taste in mouth in mornings
26	○ ○ ○	Eyelids swollen, puffy	81 ○ ○ ○	Bowel movements painful or difficult
27	○ ○ ○	Indigestion soon after meals	82 ○ ○ ○	Worrier, feels insecure
28	○ ○ ○	Always seems hungry; feels "lightheaded" often	83 ○ ○ ○	Feeling queasy; headache over eyes
29	○ ○ ○	Digestion rapid	84 ○ ○ ○	Greasy foods upset
30	○ ○ ○	Vomiting frequent	85 ○ ○ ○	Stools light colored
31	○ ○ ○	Hoarseness frequent	86 ○ ○ ○	Skin peels on foot soles
32	○ ○ ○	Breathing irregular	87 ○ ○ ○	Pain between shoulder blades
33	○ ○ ○	Pulse slow; feels "irregular"	88 ○ ○ ○	Use laxatives
34	○ ○ ○	Gagging reflex slow	89 ○ ○ ○	Stools alternate from soft to watery
35	○ ○ ○	Difficulty swallowing	90 ○ ○ ○	History of gallbladder attacks or gallstones
36	○ ○ ○	Constipation, diarrhea alternating	91 ○ ○ ○	Sneezing attacks
37	○ ○ ○	"Slow starter"	92 ○ ○ ○	Dreaming, nightmare type bad dreams
38	○ ○ ○	Get "chilled" infrequently	93 ○ ○ ○	Bad breath (halitosis)
39	○ ○ ○	Perspire easily	94 ○ ○ ○	Milk products cause distress
40	○ ○ ○	Circulation poor, sensitive to cold	95 ○ ○ ○	Sensitive to hot weather
41	○ ○ ○	Subject to colds, asthma, bronchitis	96 ○ ○ ○	Burning or itching anus
		Group 3	97 ○ ○ ○	Crave sweets
42	○ ○ ○	Eat when nervous		**GROUP 6**
43	○ ○ ○	Excessive appetites	98 ○ ○ ○	Loss of taste for meat
44	○ ○ ○	Hungry between meals	99 ○ ○ ○	Lower bowel gas several hours after eating
45	○ ○ ○	Irritable before meals	100 ○ ○ ○	Burning stomach sensations, eating relieves
46	○ ○ ○	Get "shaky" if hungry	101 ○ ○ ○	Coated tongue
47	○ ○ ○	Fatigue, eating relieves	102 ○ ○ ○	Pass large amounts of foul-smelling gas
48	○ ○ ○	"Lightheaded" if meals delayed	103 ○ ○ ○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4
49	○ ○ ○	Heart palpitates if meals missed or delayed	104 ○ ○ ○	Mucous colitis or "irritable bowel"
50	○ ○ ○	Afternoon headaches	105 ○ ○ ○	Gas shortly after eating
51	○ ○ ○	Overeating sweets upsets	106 ○ ○ ○	Stomach "bloating" after eating

	1 2 3	GROUP 7A		1 2 3	

107	O O O	Insomnia	170	O O O	Weakness after colds, influenza
108	O O O	Nervousness	171	O O O	Exhaustion - muscular and nervous
109	O O O	Can't gain weight	172	O O O	Respiratory disorders
110	O O O	Intolerance to heat			**GROUP 8**
111	O O O	Highly emotional	173	O O O	Apprehension
112	O O O	Flush easily	174	O O O	Irritability
113	O O O	Night sweats	175	O O O	Morbid fears
114	O O O	Thin, moist skin	176	O O O	Never seems to get well
115	O O O	Inward trembling	177	O O O	Forgetfulness
116	O O O	Heart palpitates	178	O O O	Indigestion
117	O O O	Increased appetite without weight gain	179	O O O	Poor appetite
118	O O O	Pulse fast at rest	180	O O O	Craving for sweets
119	O O O	Eyelids and face twitch	181	O O O	Muscular soreness
120	O O O	Irritable and restless	182	O O O	Depression; feelings of dread
121	O O O	Can't work under pressure	183	O O O	Noise sensitivity
		GROUP 7B	184	O O O	Acoustic hallucinations
122	O O O	Increase in weight	185	O O O	Tendency to cry without reason
123	O O O	Decrease in appetite	186	O O O	Hair is coarse and/or thinning
124	O O O	Fatigue easily	187	O O O	Weakness
125	O O O	Ringing in ears	188	O O O	Fatigue
126	O O O	Sleepy during day	189	O O O	Skin sensitive to touch
127	O O O	Sensitive to cold	190	O O O	Tendency toward hives
128	O O O	Dry or scaly skin	191	O O O	Nervousness
129	O O O	Constipation	192	O O O	Headache
130	O O O	Mental sluggishness	193	O O O	Insomnia
131	O O O	Hair coarse, falls out	194	O O O	Anxiety
132	O O O	Headaches upon arising, wear off during day	195	O O O	Anorexia
133	O O O	Slow pulse, below 65	196	O O O	Inability to concentrate; confusion
134	O O O	Frequency of urination	197	O O O	Frequent stuffy nose; sinus infections
135	O O O	Impaired hearing	198	O O O	Allergy to some foods
136	O O O	Reduced initiative	199	O O O	Loose joints
		GROUP 7C			**FEMALE ONLY**
137	O O O	Failing memory	200	O O O	Very easily fatigued
138	O O O	Low blood pressure	201	O O O	Premenstrual tension
139	O O O	Increased sex drive	202	O O O	Painful menses
140	O O O	Headaches, "splitting or rending" type	203	O O O	Depressed feelings before menstruation
141	O O O	Decreased sugar tolerance	204	O O O	Menstruation excessive and prolonged
		GROUP 7D	205	O O O	Painful breasts
142	O O O	Abnormal thirst	206	O O O	Menstruate too frequently
143	O O O	Bloating of abdomen	207	O O O	Vaginal discharge
144	O O O	Weight gain around hips or waist	208	O O O	Hysterectomy / ovaries removed
145	O O O	Sex drive reduced or lacking	209	O O O	Menopausal hot flashes
146	O O O	Tendency to ulcers, colitis	210	O O O	Menses scanty or missed
147	O O O	Increased sugar tolerance	211	O O O	Acne, worse at menses
148	O O O	Women: menstrual disorders	212	O O O	Depression of long standing
149	O O O	Young girls: lack of menstrual function			**MALE ONLY**
		GROUP 7E	213	O O O	Prostate trouble
150	O O O	Dizziness	214	O O O	Urination difficult or dribbling
151	O O O	Headaches	215	O O O	Night urination frequent
152	O O O	Hot flashes	216	O O O	Depression
153	O O O	Increased blood pressure	217	O O O	Pain on inside of legs or heels
154	O O O	Hair growth on face or body (female)	218	O O O	Feeling of incomplete bowel evacuation
155	O O O	Sugar in urine (not diabetes)	219	O O O	Lack of energy
156	O O O	Masculine tendencies (female)	220	O O O	Migrating aches and pains
		GROUP 7F	221	O O O	Tire too easily
157	O O O	Weakness, dizziness	222	O O O	Avoids activity
158	O O O	Chronic fatigue	223	O O O	Leg nervousness at night
159	O O O	Low blood pressure	224	O O O	Diminished sex drive
160	O O O	Nails weak, ridged			
161	O O O	Tendency to hives			
162	O O O	Arthritic tendencies			
163	O O O	Perspiration increase			
164	O O O	Bowel disorders			
165	O O O	Poor circulation			
166	O O O	Swollen ankles			
167	O O O	Crave salt			
168	O O O	Brown spots or bronzing of skin			
169	O O O	Allergies - tendency to asthma			

List the five main complaints you have in the order of their importance:

1._____

2._____

3_____

4. _____

5. _____

Austin 3D Health

Note: this document is a form that you can fill out. Once filled out you can save it to your PC, then email it to admin@austin3dhealth.com. Please include your name in the filename when you save it to your PC.

Answer Y or N in the following boxes	Living?	Age or Age at Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure		High Cholesterol	Stroke	Other, Description
Father														
Father's Mother														
Father's Father														
Father's Grandparents														
Father's Siblings														
Mother														
Mother's Mother														
Mother's Father														
Mother's Grandparents														
Mother's Siblings														
Your Siblings														
Your Children														

Austin 3D Health

Please Check Symptoms that apply:

Chest:	☐ Pain	☐ Tightness	☐ Palpitations	☐ Reflux		
Headaches:	☐ Sharp	☐ Dull	☐ Migraines	☐ Nausea	☐ Vomiting	
Ears:	☐ Ringing	☐ Drainage	☐ Itch	☐ Dizzy	☐ Ache	
Eyes:	☐ Blurry	☐ Floaters	☐ Dry	☐ Puffy	☐ Twitch	☐ Circles
Sinus:	☐ Post-Nasal Drip	☐ Sneezing	☐ Sore Throat	☐ Asthma	Cough Dry ☐ Mucus ☐	
Allergies	☐ Food	☐ Environmental				
Fever:	☐ Day	☐ Late Afternoon	☐ Night	☐ Low Grade	Are you always:	☐ Hot ☐ Cold

For Practitioner's Use Only

Blood Pressure: _____ / _____

Pulse: _____

Tougue: _____

Diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Westlake Oaks Executive Park
1101 S Capital of Texas Hwy
Bldg. K, Ste. 100
Austin, Texas 78746
Phone: 512-915-1999
Fax: 855-915-1900

Notice of Understanding and Agreement:

1. I fully understand that the Nutrition Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures.

2. The services performed by the Nutrition Consultant are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.

3. I understand that as a Nutrition Consultant the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.

4. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

According to the Federal Food, Drug and Cosmetic Act, as amended,
Section 201 (g) (1), the term "DRUG' is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease. A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advise is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above:

Signed _____ Date_____

Print name _____

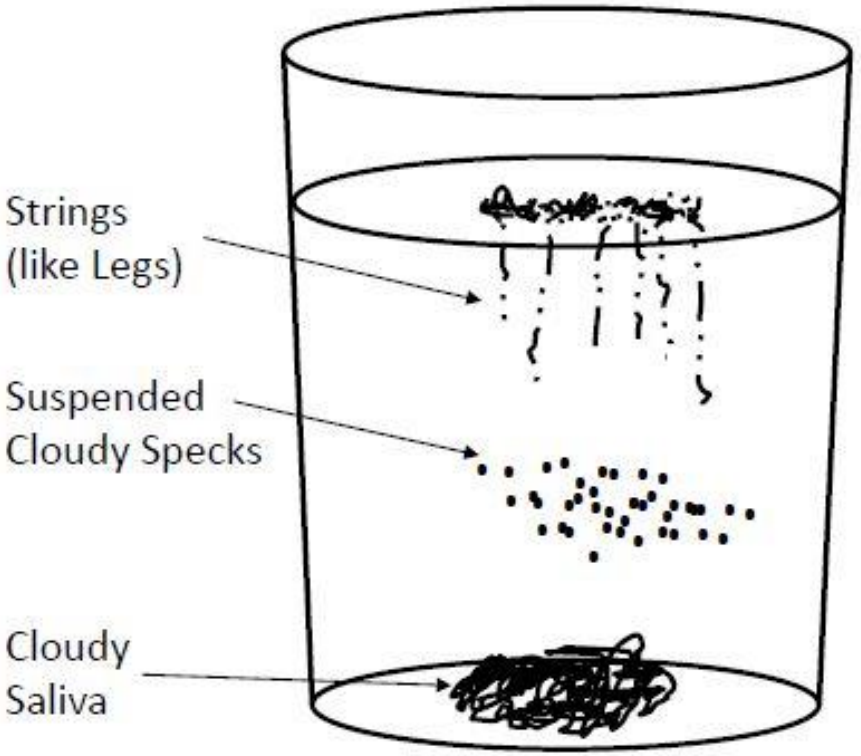
PATIENT NAME:

MEDICAL HISTORY/EMOTIONAL STRESSORS/ TRAUMAS

Please use this form to list all major life events such as career changes, trips, medications, moves, illnesses, accidents, injuries, marriages, births, deaths, and new relationships, along with any medical conditions & current symptoms.

Dates:	Situation/ Condition	Provider	City

Do-It-Yourself Candida Test



- Place clean glass with water on counter. Do not touch the glass after this point.
- Spit into the glass your first sputum in the morning before putting anything in your mouth.
- Check the water every 15 minutes for up to one hour.
- If you see strings (like legs) traveling down into the water from the saliva floating on top, or "cloudy" saliva that sinks to the bottom of the glass, or cloudy specks suspended in the water then the saliva is carrying a fungal overgrowth.
- If no strings and the saliva is floating after 1 hour it appears you are Candida free.
- If positive for Candida call the office and order:
  - ✓ GI Synergy – take 1 packet AM/PM
  - ✓ Repairvite – use 1 scoop per day

  You will also need to reduce your sugar to less than 10-grams per day.