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## **Integrative Consultation Form**

*I look forward to your first visit in our office!* Please find a quiet moment to complete this questionnaire to bring to your appointment. I have carefully chosen these questions to address all aspects of your health. Your answers will help me to work with you in a way that best meets your health care needs. Feel free to skip any questions that you do not wish to answer. If there are questions that you prefer not to answer in writing but wish to discuss in-person, we may do so at your appointment.

**Today's Date:** \_\_\_\_\_ **Preferred Pronouns** \_\_\_\_\_

**First Name** \_\_\_\_\_ **Middle Initial** \_\_\_\_\_ **Last Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_ **E-mail Address** \_\_\_\_\_

**Phone Number** Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Where can I leave a confidential message? (check one) \_\_\_\_Home \_\_\_\_Work \_\_\_\_Cell

**Who referred you to my practice?** \_\_\_\_\_

**Birth order** (Check One) Only child \_\_\_\_ first \_\_\_\_ middle \_\_\_\_ or last \_\_\_\_

Please describe the **major expectations** that you have of your Integrative Consultation:  
What are your health goals? What are your health concerns?

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What health problems would you like us to address with your consultation? Please rank by priority:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Please list the name of **physicians and complementary medicine providers** who have treated you in the past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment From	To

Please list the name of **psychiatrists, psychologists, counselors and psychotherapists** who have treated you in the past:

Name	Telephone # (optional)	Profession/Specialty	Dates of treatment From	To

Please list the name and diagnosis date of any current medical conditions.

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Please list the name and diagnosis date of any past or childhood medical conditions.

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Please list any diagnostic studies you have had done in the past and the date-  
(CT, MRI, ultrasound, colonoscopy, EGD, EKG, Bone density scan, etc.)

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What **medications and remedies** are you currently taking? This includes over-the-counter medications, homeopathic and herbal remedies, and nutritional supplements. Use the back of this page if need to add more or bring a list with you to attach.

Name	Dose or quantity per day/ Brand or Manufacturer	When did you start it? Why?

### ALLERGIES

Are you allergic to or have you had a “bad reaction” to any medications or other substances? \_\_\_\_YES \_\_\_\_NO

If yes, please specify drug(s), substance(s) and type of reaction: \_\_\_\_\_

\_\_\_\_\_

**Environmental allergies** \_\_\_\_YES \_\_\_\_NO. If yes, please describe.

\_\_\_\_\_

\_\_\_\_\_

**Food allergies** \_\_\_\_YES \_\_\_\_NO. If yes, please describe.

\_\_\_\_\_

Exposure to toxic metals at job or home \_\_\_\_YES \_\_\_\_NO. If yes, please describe.

\_\_\_\_\_

Do you have dental amalgams (silver fillings) or root canals? \_\_\_\_YES \_\_\_\_NO

Please list number of times you have had antibiotics as a Child\_\_\_\_\_ Teen\_\_\_\_\_ Adult\_\_\_\_\_

Please list number of times you have taken oral/IM/IV steroids as a Child\_\_\_\_\_ Teen\_\_\_\_\_ Adult\_\_\_\_\_

Please list any **hospitalizations or surgeries** you have had:

Reason for hospitalization or surgery	Date

What **exercise activities** do you do in a typical week?

Activity Type	Times per week	Minutes per time

Would you like to discuss your exercise regimen? \_\_\_\_ YES \_\_\_\_ NO

## **DIET**

Do you skip meals? \_\_\_\_\_

Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian? Vegan?

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What and how much do you drink on a typical day? (i.e.: water, caffeine drinks, soda, etc.)

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How would you describe your relationship with food? \_\_\_\_\_

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What **foods** do you eat on a regular basis?

Breakfast foods	
Lunch foods	
Dinner foods	
Foods you crave (sugar, chocolate, soda, coffee, etc.)	
Foods you dislike	
Snack foods	
Comfort foods	
Food allergies	

How many of your meals (including breakfast and lunch) each week are prepared in a restaurant? \_\_\_\_\_

Would you like to discuss your eating habits and diet? \_\_\_\_YES \_\_\_\_NO

Anything about your diet I should know? \_\_\_\_\_

## GUT

How often do you have a bowel movement? \_\_\_\_\_

Do you have the following? (please circle) small stools, hard stools, diarrhea, loose stools, undigested food in stools, blood in stool, excessive gas, distended belly after eating, foods that make you have an urgent need to have a bowel movement? What foods? \_\_\_\_\_

Have you had a colonoscopy and/or EGD? \_\_\_\_YES \_\_\_\_NO Date\_\_\_\_\_ Reason\_\_\_\_\_

## ALCOHOL/BEVERAGE/RECREATIONAL INTAKE

Do you consume any of the following?

	Yes	No	If yes, how much per week	If quit, when
Beer or wine				
Liquor				
Tobacco products/ Vape				
Marijuana, cocaine or other drugs: (please specify)				
Coffee, coke or other drinks with caffeine (please specify)				

Do you feel that you have or had a problem with any of the substances listed above? \_\_\_\_YES \_\_\_\_NO

Have you ever had to cut down on your drinking? \_\_\_\_YES \_\_\_\_NO

Do you get annoyed when someone asks about your drinking? \_\_\_\_YES \_\_\_\_NO

Do you ever feel guilty about your drinking? \_\_\_\_YES \_\_\_\_NO

Do you ever make excuses for drinking or for your behavior while drinking? \_\_\_\_\_YES \_\_\_\_\_NO

## **SMOKING**

Do you smoke? \_\_\_\_\_YES \_\_\_\_\_NO If yes, how long have you been smoking? \_\_\_\_\_

Have you smoked in the past? \_\_\_\_\_YES \_\_\_\_\_NO If yes, how long? \_\_\_\_\_

Do you have/have you had smoke exposure at home? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

## **SLEEP**

Overall do you feel that you get enough **sleep**? \_\_\_\_\_YES \_\_\_\_\_NO

What time do you go to bed? \_\_\_\_\_

What time do you wake up? \_\_\_\_\_

Do you wake up during the middle of the night? \_\_\_\_\_YES \_\_\_\_\_NO How often? \_\_\_\_\_ About what time? \_\_\_\_\_ Are you able to go back to sleep? \_\_\_\_\_

Do you feel rested upon waking? \_\_\_\_\_YES \_\_\_\_\_NO

Do you take anything to help sleep? \_\_\_\_\_YES \_\_\_\_\_NO What do you take? \_\_\_\_\_

## **WOMEN'S HEALTH**

Age of first menstrual period \_\_\_\_\_ Date of last menstrual period \_\_\_\_\_

Are your periods regular? \_\_\_\_\_YES or \_\_\_\_\_NO

First day of most recent menstrual period? \_\_\_\_\_ Usual Flow: \_\_\_\_\_Heavy \_\_\_\_\_ Moderate \_\_\_\_\_ Light

Length of bleeding in days \_\_\_\_\_ Number of days between periods? \_\_\_\_\_

Do you have (please circle): Painful Periods, Missed Periods, Spotting Between Periods, Excessive Vaginal Bleeding, Pain with intercourse, bleeding after intercourse, Unusual Discharge/Infection, Recurring Vaginal Infections, Low Libido

If you have gone through menopause, have you had any post-menopausal bleeding? \_\_\_\_\_YES \_\_\_\_\_NO

Date of last: PAP/HPV Screen \_\_\_\_\_ Pelvic exam \_\_\_\_\_

Mammogram/Breast Imaging \_\_\_\_\_ Breast exam \_\_\_\_\_

History of abnormal mammogram? \_\_\_\_\_YES \_\_\_\_\_NO Date/Diagnosis \_\_\_\_\_

History of breast biopsy? \_\_\_\_ YES \_\_\_\_ NO Date/Diagnosis \_\_\_\_\_

Please list any Family members with Breast Cancer & age at diagnosis? \_\_\_\_\_

Have you ever had an abnormal PAP? \_\_\_\_ YES \_\_\_\_ NO

If yes, when/treatment \_\_\_\_\_

Number of: Pregnancies \_\_\_\_ Live Births \_\_\_\_ Abortions \_\_\_\_ Miscarriages \_\_\_\_

Have you experienced complications during pregnancy/delivery/or post partum? \_\_\_\_ YES \_\_\_\_ NO

If yes, please explain. \_\_\_\_\_

### **Contraceptive History**

Please circle the method of contraception you are currently using:

Birth Control Pills Type \_\_\_\_\_ Diaphragm/Cap \_\_\_\_\_

IUD Type \_\_\_\_\_ Nexplanon, Depo Provera, Condom and/or Foam, Suppository

Total Years of Use \_\_\_\_\_ Date of Last Change \_\_\_\_\_

Tubal Ligation \_\_\_\_ YES \_\_\_\_ NO

Hysterectomy \_\_\_\_ YES \_\_\_\_ NO

Partner with Vasectomy \_\_\_\_ YES \_\_\_\_ NO

Other method \_\_\_\_\_

Problems with current method \_\_\_\_\_

Have you used Contraceptive in the past? \_\_\_\_ YES \_\_\_\_ NO For how long? \_\_\_\_\_

What types? \_\_\_\_\_ During what years? \_\_\_\_\_

Please list any history of sexually transmitted infections and date of diagnosis? \_\_\_\_\_

## BIRTH HISTORY

Did your mother have a vaginal or cesarean section when you were born? \_\_\_\_\_ Vaginal \_\_\_\_\_ Cesarean  
\_\_\_\_\_ I do not know

Were you born at term? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ I do not know

If No, what gestational age were you born? \_\_\_\_\_

Were you breastfed? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ I do not know If Yes, for how long? \_\_\_\_\_

Have you experienced any traumatizing events in your life? \_\_\_\_\_

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What are the greatest sources of **stress** in your life? Describe activities or techniques you use to relieve stress.

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What are the greatest sources of **comfort** in your life? What brings you joy in your life?

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Who are the people, including members of your family, or animals **who play a very important role in your life?**

Name	Relationship to you	Age	Where do they live?

Who lives with you? \_\_\_\_\_

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Are you satisfied with your **personal relationships**? \_\_\_\_YES \_\_\_\_NO Please describe: \_\_\_\_\_

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If you are a **parent**, do you have any concerns about parenting? \_\_\_\_YES \_\_\_\_NO

If yes, please describe:

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Do you consider yourself heterosexual, homosexual, bisexual, transgender, other?

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Have you, or a close family member, ever experienced **emotional, physical, mental or sexual abuse or assault**? \_\_\_\_YES \_\_\_\_NO If yes, please explain: \_\_\_\_\_

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Do you use any form of **birth control** or **protection from sexually transmitted infections**? \_\_\_\_YES \_\_\_\_NO

If yes, please describe:

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Are you **sexually active**? \_\_\_\_YES \_\_\_\_NO With **men, women, or both**? \_\_\_\_\_

Are you satisfied with your **sexual relationships**? \_\_\_\_YES \_\_\_\_NO

If no, please describe:

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Do you belong to an **organized religion or spiritual group**? \_\_\_\_YES \_\_\_\_NO

Please describe your current religious or spiritual practice:

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Are you currently a **student**? \_\_\_\_YES \_\_\_\_NO If yes, where? \_\_\_\_\_

How many **years of education** have you completed? \_\_\_\_\_

Do you have any **difficulties with learning**? \_\_\_\_ YES \_\_\_\_ NO

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

What is your **job or occupation**? \_\_\_\_\_ How many hours a week do you work? \_\_\_\_

Are you satisfied with your **work**? \_\_\_\_ YES \_\_\_\_ NO

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything about your **work that negatively affects your mental or physical health**?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is your current **annual household income**? (check one)

\_\_\_\_ \$20,000 \_\_\_\_ \$20,000-\$40,000 \_\_\_\_ \$40,000-\$60,000 \_\_\_\_ \$60,000-\$80,000 \_\_\_\_ \$80,000-\$100,000  
\_\_\_\_ \$100,000-\$200,000 \_\_\_\_ >\$200,000

Do you have any **concerns** about your current **FINANCIAL** situation? \_\_\_\_ YES \_\_\_\_ NO

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

Do you have any **concerns** about your current **LIVING** situation? \_\_\_\_ YES \_\_\_\_ NO

If yes, please describe:

\_\_\_\_\_  
\_\_\_\_\_

Is there **any other information** about you that you feel is important to tell me?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please attach a **copy of a typical weekday and weekend schedule** for yourself. If you are unsure, track one day during the week and one on the weekend before you come in for your appointment (When you wake up, when you go to bed, typical meals/time, exercise frequency/duration, activities, down time, screen time).

When was the last time you felt well?

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How are your current health issues impacting your ability to enjoy life?

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Did something trigger your change in your health?

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Do you have insights or hunches into what's affecting your health?

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What do you feel needs to happen for you to get better?

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What makes you feel better?

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What makes you feel worse?

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How do you want to feel?

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What does health look like or mean to you?

What interested you most about this practice? What are your expectations of your health provider?

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What do you hope to achieve in your visit?

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What do you see as your role in your health plan?

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What would a successful outcome look like to you and in what time frame?

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What are your 1year health goals? 5year health goals? 10year health goals?

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If you could do one thing in your life, name your **biggest dream, your life’s mission**, what would it be?

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<b>Please check the health problems that apply to each family member</b>	<b>Self</b>	<b>Grandparent</b>	<b>Father</b>	<b>Mother</b>	<b>Siblings</b>	<b>Child</b>
Alcoholism						
Allergies/Hay fever						
Anemia						
Arthritis/Rheumatism/Lupus						
Asthma						
Birth Defects						
Bleeding Disorders						
Cancer or Tumor						
Colitis or Crohn's						
Congenital Heart Disease						
Depression/Anxiety						
Diabetes						
Emphysema, COPD						
Epilepsy, Seizures						
Frequent Infections						
Genetic Disease						
Glaucoma, Cataracts, Macular Degeneration						
Gonorrhea/Chlamydia/Herpes/PID						
Gout						
Alzheimer's/Dementia/Parkinson's						
Heart Disease/Heart Attacks						
High Blood Pressure						
HIV, AIDS						
Infertility						
Kidney Disease						
Liver Disease, Hepatitis						
Mental Illness/Suicide (or attempted)						
Migraine Headaches						
Nervous Breakdown						
Obesity						
Osteoporosis						
Peptic Ulcer Disease						
Autoimmune Disease						
Prostate Problems						
Psoriasis, Eczema						
Rheumatic Fever						
Stroke						
Thyroid Disease						
Tuberculosis						
Other:						

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

**POINT SCALE:**

0 = Never or almost never have the symptom severe

1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe

3 = Frequently have it, effect is not severe

4 = Frequently have it, effect is severe

**Digestive Tract**

\_\_\_\_ Nausea or Vomiting

\_\_\_\_ Diarrhea

\_\_\_\_ Constipation

\_\_\_\_ Bloating Feeling

\_\_\_\_ Belching or passing gas

\_\_\_\_ Heartburn

\_\_\_\_ Intestinal/Stomach Pain

\_\_\_\_ **Total**

**Mouth/Throat**

\_\_\_\_ Chronic Coughing

\_\_\_\_ Gagging/Frequent need to clear throat

\_\_\_\_ Sore Throat/Hoarseness/Loss of Voice

\_\_\_\_ Swollen/Discolored Tongue/Gum/Lips

\_\_\_\_ Canker Sores

\_\_\_\_ **Total**

**Weight**

\_\_\_\_ Binge Eating/Drinking

\_\_\_\_ Craving Certain Foods

\_\_\_\_ Excessive Weight

\_\_\_\_ Compulsive Eating

\_\_\_\_ Water Retention

\_\_\_\_ Underweight

\_\_\_\_ **Total**

**Energy/Activity**

\_\_\_\_ Fatigue/Sluggishness

\_\_\_\_ Apathy/Lethargy

\_\_\_\_ Hyperactivity

\_\_\_\_ Restlessness

\_\_\_\_ **Total**



## Emotions

- \_\_\_ Mood Swings
- \_\_\_ Anxiety/Fear/Nervousness
- \_\_\_ Anger/Irritability/Aggressiveness
- \_\_\_ Depression
- \_\_\_ **Total**

## Ears

- \_\_\_ Itchy Ears
- \_\_\_ Earaches/Ear Infections
- \_\_\_ Drainage from ear
- \_\_\_ Ringing in ears/Hearing loss
- \_\_\_ **Total**

## Mind

- \_\_\_ Poor Memory
- \_\_\_ Confusion/Poor Comprehension
- \_\_\_ Poor Concentration
- \_\_\_ Poor Physical Coordination
- \_\_\_ Difficult in Making Decisions
- \_\_\_ Stuttering/Stammering
- \_\_\_ Slurred Speech
- \_\_\_ Learning Disabilities
- \_\_\_ **Total**

## Nose

- \_\_\_ Stuffy Nose
- \_\_\_ Sinus Problems
- \_\_\_ Hay Fever
- \_\_\_ Sneezing Attacks
- \_\_\_ Excessive Mucus Formation
- \_\_\_ **Total**

## Eyes

- \_\_\_ Watery/Itchy Eyes
- \_\_\_ Swollen/Reddened/Sticky Eyelids
- \_\_\_ Bags/Dark Circles under Eyes
- \_\_\_ Blurred or Tunnel Vision (Does not include near-or-far-sightedness)
- \_\_\_ **Total**

## Joint/Muscles

\_\_\_\_ Pain/Arches in Joints

\_\_\_\_ Arthritis

\_\_\_\_ Stiffness/Limitation of Movement

\_\_\_\_ Pain/Aches in Muscles

\_\_\_\_ Feeling of Weakness or Tiredness

\_\_\_\_ **Total**

## Heart

\_\_\_\_ Irregular/Skipped Heartbeat

\_\_\_\_ Rapid/Pounding Heartbeat

\_\_\_\_ Chest Pain

\_\_\_\_ **Total**

## Other

\_\_\_\_ Frequent Illness

\_\_\_\_ Frequent or Urgent Urination

\_\_\_\_ Genital Itch or Discharge

\_\_\_\_ **Total**

## Head

\_\_\_\_ Headaches

\_\_\_\_ Faintness

\_\_\_\_ Dizziness

\_\_\_\_ Insomnia

\_\_\_\_ **Total**

## Skin

\_\_\_\_ Acne

\_\_\_\_ Hives/Rashes/Dry Skin

\_\_\_\_ Hair loss

\_\_\_\_ Flushing/Hot Flushes

\_\_\_\_ Excessive Sweating

\_\_\_\_ **Total**

## Lungs

\_\_\_\_ Chest Congestion

\_\_\_\_ Asthma/Bronchitis

\_\_\_\_ Shortness of Breath/Difficulty

\_\_\_\_ **Total**

## Gyn

- \_\_\_\_ Breast Cysts
- \_\_\_\_ Breast Lumps
- \_\_\_\_ Breast Tenderness
- \_\_\_\_ Ovarian Cysts
- \_\_\_\_ Poor Libido (Sex Drive)
- \_\_\_\_ Endometriosis
- \_\_\_\_ Fibroids
- \_\_\_\_ Infertility
- \_\_\_\_ Vaginal Discharge
- \_\_\_\_ Vaginal Odor
- \_\_\_\_ Vaginal Itch
- \_\_\_\_ Vaginal Pain
- \_\_\_\_ **Total**

## Premenstrual Symptoms

- \_\_\_\_ Bloating
- \_\_\_\_ Breast Tenderness
- \_\_\_\_ Carbohydrate Craving
- \_\_\_\_ Chocolate Craving
- \_\_\_\_ Constipation
- \_\_\_\_ Decreased Sleep
- \_\_\_\_ Diarrhea
- \_\_\_\_ Fatigue
- \_\_\_\_ Increased Sleep
- \_\_\_\_ Irritability
- \_\_\_\_ **Total**

## Menstrual Symptoms

\_\_\_\_ Cramps  
\_\_\_\_ Heavy Periods  
\_\_\_\_ Irregular Periods  
\_\_\_\_ No Periods  
\_\_\_\_ Scanty Periods  
\_\_\_\_ Spotting Between  
\_\_\_\_ **Total**

## Peri/Menopausal Symptoms

\_\_\_\_ Hot Flashes  
\_\_\_\_ Mood Swings  
\_\_\_\_ Concentration Problems  
\_\_\_\_ Headaches  
\_\_\_\_ Joint Pain  
\_\_\_\_ Vaginal Dryness  
\_\_\_\_ Decreased Libido (Sex Drive)  
\_\_\_\_ Loss of Control of Urine  
\_\_\_\_ Palpitations  
\_\_\_\_ **Total**

\_\_\_\_ **GRAND TOTAL**