

HELENE B. LEONETTI MD

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**“Lifestyle Enhancement for Women”
Questionnaire**

Name: _____ Age: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security No: _____

Email: _____ Visit www.helenebleonettimd.com to sign up for my mailing list to receive information on events.

Occupation: _____

Marital Status: Married Divorced Widowed Other

MEDICAL HISTORY

Number of Pregnancies: _____ Number of Births: _____

Ages of Children: _____ Last Menstrual Period: _____

Past Illnesses:

Past Surgeries:

Allergies: _____

Medications Taken Daily: _____

NUTRITIONAL DIARY

Breakfast

Lunch

Dinner

_____	_____	_____
_____	_____	_____
_____	_____	_____

Do You Drink: Coffee Tea (circle one) If so, how much? _____

How Many 8 Ounce Servings of Water Do You Drink Daily? _____

Do You Smoke? Yes No How much? _____

Do You Drink Alcohol? Yes No How much? _____

How Often Do You Move Your Bowels? _____

What is the Consistency of Your Bowel Movements? _____

How Many Hours Do You Sleep Nightly? _____

Do You Exercise? How Often?
 Yes No Daily Weekly Other

List Food, Vitamin, and Herbal Supplements Taken Daily:

PERSONAL DIARY

In a Few Words, What Makes Your Heart Sing?

What Do You Desire from This Visit?
