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## Female Medical History

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Preventative Medical Care:

- Medical/GYN Exam in the last year.
- Mammogram in the last 12 months.
- Bone Density in the last 12 months.
- Thermogram in last 12 months.

### Habits:

- I smoke cigarettes or cigars \_\_\_\_\_ per day.
- I drink alcoholic beverages:  
 Amount: \_\_\_\_\_ per day \_\_\_\_\_  
 per week \_\_\_\_\_ per month \_\_\_\_\_
- Amount of coffee: \_\_\_\_\_
- Amount of soda \_\_\_\_\_ a day.
- Energy drinks \_\_\_\_\_ a day.
- Exercise \_\_\_\_\_ times a week.

### Your Family Medical History:

- Arthritis, Gout
- Asthma, Hay Fever
- Cancer (type): \_\_\_\_\_
- Chemical Dependency
- Diabetes
- Heart Disease, Strokes
- High Blood Pressure
- Kidney Disease
- Anxiety/Depression
- Other: \_\_\_\_\_

### Your Medical Illnesses:

- High blood pressure.
- Heart bypass.
- High cholesterol.
- Hypertension.
- Heart Disease.
- Stroke and/or heart attack.
- Blood clot and/or a pulmonary emboli.
- Arrhythmia.
- Any form of Hepatitis or HIV.
- Lupus or other auto immune disease.
- Fibromyalgia.
- Trouble passing urine or take Flomax or Avodart.
- Chronic liver disease (hepatitis, fatty liver, cirrhosis).
- Diabetes.
- Thyroid disease.
- Arthritis.
- Depression/anxiety.
- Other \_\_\_\_\_
- Cancer (type): \_\_\_\_\_  
 Year: \_\_\_\_\_

Any known drug allergies: \_\_\_\_\_

Have you ever had any issues with anesthesia?  Yes  No

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

Medications Currently Taking: \_\_\_\_\_

Past Hormone Replacement Therapy: \_\_\_\_\_

Nutritional/Vitamin Supplements: \_\_\_\_\_

Surgeries, list all and when: \_\_\_\_\_

Last menstrual period (estimate year if unknown): \_\_\_\_\_

Pregnancies: \_\_\_\_\_ Live Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

\_\_\_\_\_  
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