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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:

( ) 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: _____

_____

_____