FEMALE MEDICAL HISTORY

Date: _______________ Age: _______________ Family M. D.: ____

Check any problems you are having:
☐ Hot Flashes ☐ Sleep problems ☐ Fatigue ☐ Low Sex Drive ☐ Loss of Enthusiasm for Life
☐ Loss of Muscle Mass ☐ Irritability ☐ Migraine Headaches ☐ Urinary Frequency ☐ Bladder Leakage
☐ Anxiousness or Jitteriness ☐ Heavy Periods ☐ Irregular Periods

Past Medical History
Do you have: ☐ High Blood Pressure ☐ Diabetes ☐ Heart Disease ☐ Thyroid Disease
☐ Sleep Apnea ☐ Cancer (type) ________________________________ ☐ Other Diseases __________________________

Do you see a doctor any other medical problems? List: ____
____

Date of last Mammogram: _______________________ Date of last Pap Smear or yearly exam:_________________________

Have you ever had Breast Cancer? ☐ Yes ☐ No Have you had a Hysterectomy? ☐ Yes ☐ No

Ovaries removed? ☐ Yes ☐ No

List any major surgeries you have had: ____

Are you using birth control? ☐ Yes ☐ No If so, what kind?____

List any medications you take:____

Your mother's history: ☐ Heart Disease ☐ Diabetes ☐ Cancer (type) ____
Other Diseases____

Your father's history: ☐ Heart Disease ☐ Diabetes ☐ Cancer (type) ____
Other Diseases____

Are you allergic to any medications? ☐ Yes ☐ No If so, list: ____

Alcohol Use: ☐ Never ☐ Occasionally ☐ Frequently Cigarette Use: ☐ Never ☐ Occasionally ☐ Frequently

*********** FOR OFFICE USE ONLY ***

Chart No. __________ Ht:__________ Wt:__________ BP:__________ G:__________ P:__________

Patient Here For: ☐ Hormone Consult ☐ Pellet Insertion