Medical History Form Females

This form is confidential. Please fill out completely.

Patient Name_____ Date: _____

Name Prefer to be called _____

Address _____ City _____ State ____ Zip Code_____

Sex _____ Date of Birth _____ Age _____ Race _____

Phone: Home_____ Cell _____ Work _____

Email: _____

Preferred Contact Method _____

May we leave a message on a home machine or voice mail? _____

Social Security Number _____ Occupation _____

Employer _____ Language Preferred _____ Ethnicity _____

Marital status _____ Spouse's Name _____ Date of Birth _____

Emergency Contact Name _____

Phone number _____ Relationship to patient _____

Who referred you to our practice? _____

Pharmacy name _____

Phone Number _____

Address_____ City _____ State _____ Zip Code _____

Primary Care Physician _____

Address _____City _____State _____ Zip Code_____

Describe the main reason for your visit today:

_____
_____
_____

How long have you been experiencing these symptoms?

Any other symptoms associated with your chief complaint?

_____
_____

Have you found anything that makes your symptoms better or worse?

_____
_____

Does this problem affect your daily life? How?

Have you ever received treatment for your symptoms? Yes/ No If yes, please list the physician and treatment including medication. _____

Social History

(please circle yes or no)

Do you smoke? Yes / No If yes, # packs per day _____ How long? _____ Past Smoker? Yes / No

Do you use smokeless tobacco? Yes/ No If yes, how long? _____

Do you drink alcohol? Yes/ No If yes, how much and how often? _____

Caffeine Use Yes/ No If yes, please state amount and frequency. _____

Do you use recreational drugs such as Cocaine, Marijuana or Methamphetamine? Yes/No If yes, please list the drug name and frequency: _____

Do you exercise? Yes/ No If yes, please describe your exercise habits.

_____

Medical History

Are you allergic to any Medication? Yes/No If yes, list the medication and reaction.

Do you take any medication? Yes/ No. If yes, please list (include herbal medication)

Medication	Dosage	Frequency

Have you been hospitalized or undergone a surgical procedure? Yes/ No If yes, please list:

Surgery/Illness Date Physician Hospital

_____

_____

_____

Last Physical Exam: Physician _____ Date _____

Last Pap Smear: Physician_____ Date _____

Was your last pap smear Normal or Abnormal? _____

Last Menstrual period _____ Do you have regular periods? _____

Have you been through menopause? Yes /No / NA

Method of birth control _____

Have you ever been pregnant? Yes/ No If yes, # of times _____

Are you pregnant or breast feeding? Yes/ No

Date of last Mammogram _____ normal or abnormal? _____

Have you ever had a Bone Density Scan (DEXA) to check for osteoporosis? _____ If so, when? _____

Have you ever been on hormone replacement? If yes, please explain.	
Have you ever been on a growth hormone replacement program? If yes, please explain.	

MENTAL HEALTH		
Is stress a major problem for you?	Yes	No
Do you feel depressed often?	Yes	No
Do you panic when stressed?	Yes	No
Do you have problems with your appetite?	Yes	No
Do you cry often?	Yes	No
Have you ever attempted suicide?	Yes	No
Have you ever thought about injuring yourself?	Yes	No
Do you have difficulty sleeping?	Yes	No
Have you ever seen a counselor / Therapist?	Yes	No

If you have ever received in patient treatment for a mental health illness or for substance abuse please explain _____

Have you ever or are you experiencing any of the following? (Check all that apply)

Constitutional Symptoms
- ☐ Weight gain ____ lbs
- ☐ Fever/Chills
- ☐ Weight loss ____ lbs
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Appetite change

Eyes
- ☐ Glaucoma
- ☐ Vision loss
- ☐ Blurred/Double vision

Ear/Nose/Throat/Mouth
- ☐ Hearing loss
- ☐ Nasal congestion
- ☐ Snoring
- ☐ Mouth/throat irritation
- ☐ Tooth problems

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain/Pressure
- ☐ High/Low blood pressure
- ☐ Heart Racing/Palpitations
- ☐ Heart Failure
- ☐ Heart attack
- ☐ Sweating
- ☐ Ankle swelling
- ☐ Syncope/Passing out

Gastrointestinal
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Liver disease
- ☐ Difficulty Swallowing
- ☐ Heartburn

Integumentary
- ☐ Skin Rash
- ☐ Dry Skin
- ☐ Eczema

Genitourinary
- ☐ Urinary retention
- ☐ Pain with urination
- ☐ Kidney Disease
- ☐ Incontinence
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Sexual problems
- ☐ Vaginal dryness
- ☐ Vaginal discharge
- ☐ Frequent UTIs

Neurological
- ☐ Depression/Anxiety
- ☐ Stroke
- ☐ Insomnia
- ☐ Headache/Migraine
- ☐ Dizzy spells/Vertigo
- ☐ Seizures
- ☐ Bipolar disorder

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Easy bleeding or bruising
- ☐ Anemia
- ☐ Blood Clot (DVT or PE)

Musculoskeletal
- ☐ Muscle Wasting
- ☐ Arthritis
- ☐ Pain
- ☐ Stiffness
- ☐ Weakness

Endocrine
- ☐ Change in Sex Drive
- ☐ Cold or Heat Intolerance
- ☐ Thyroid Problems
- ☐ Blood Sugar Problems
- ☐ Change in Body Hair
- ☐ Excessive Thirst

☐ **I have not experienced any of the symptoms above**

I/My Family has a history of: (please check all that apply)

	Me	Family	Comment		Me	Family	Comment
Anemia	☐	☐	_____	Hormone Disorders	☐	☐	_____
Breast Disease	☐	☐	_____	Kidney Disease	☐	☐	_____
Cancer	☐	☐	_____	Kidney Stones	☐	☐	_____
Chronic Pain	☐	☐	_____	Liver Disease	☐	☐	_____
Depression/Anxiety	☐	☐	_____	Lung Disease	☐	☐	_____
Diabetes, Type1or2	☐	☐	_____	Neurological Disorder	☐	☐	_____
Diverticulosis	☐	☐	_____	Osteoporosis	☐	☐	_____
Endometriosis	☐	☐	_____	Overactive Bladder	☐	☐	_____
Erectile Dysfunction	☐	☐	_____	Obesity	☐	☐	_____
Fractures	☐	☐	_____	Psychological	☐	☐	_____
Gout	☐	☐	_____	Stroke	☐	☐	_____
Glaucoma	☐	☐	_____	Stomach ulcers	☐	☐	_____
Heart Disease	☐	☐	_____	Seizures	☐	☐	_____
High Cholesterol	☐	☐	_____	GERD/Acid Reflux	☐	☐	_____
HIV/AIDS	☐	☐	_____	Sickle Cell Anemia	☐	☐	_____
Hemorrhoids	☐	☐	_____	Sleep Disorders	☐	☐	_____
Headache	☐	☐	_____	Thyroid Disease	☐	☐	_____
Hepatitis	☐	☐	_____	Spine Injury/Surgery	☐	☐	_____
Allergies	☐	☐	_____	STDs	☐	☐	_____

Other: _____

Please check the hormone symptoms that apply to you

	Mild	Moderate	Severe
Low Sex Drive			
Painful intercourse			
Difficulty reaching orgasm			
Difficulty becoming aroused			
Lack of lubrication			
Hot flashes			
Mood swings			
Irritability			
Lack of energy			
Weight gain			
Depression			

If there is anything not listed on this form that you feel the physician should be aware of please list here:

_____

_____

I (the patient) agree to submit this medical history as accurately, completely, and to the best of my recollection. I agree that failure to provide truthful, accurate and complete information on this history form to 1513, LLC to the physicians of 1513, LLC could result in inappropriate treatment. I also understand that this record submitted will be held in the highest confidentiality as set by the Health Information Act as well as other established law and will only be used to further my medical treatment.

_____ _____

Print Name **Signature** **Date**

Reviewed by _____