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www.youthfulbalance.net

BP:

HR:

RR:

BMI:

BF:

Patient Medical History Form

Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Age:_____ Male:____ Female:____

Height: _____ Weight: _____

Home Phone:_____ Cell Phone:_____

Email:_____

How did you hear about us: _____

Primary Care Physician: _____

List all medications, including vitamins and supplements that you are taking:

_____

_____

Drug sensitivities and/or drug allergies:

_____

_____

Please list any hospitalizations and/or surgeries or additional information regarding your health:

_____

Do you drink alcohol? _____ If so, how often? _____

Do you smoke? _____ If so, how often? _____

Do you exercise? _____ If so, how often? _____

Currently pregnant? _____

Have you ever had a hysterectomy? _____

If so, total or partial? _____ When? _____

Form of contraception, if any? _____

Date of last period _____ Was it normal? _____

Date of last mammogram _____ Was it normal? _____

Date of last pap smear _____ Was is normal? _____

Please check yes or no if you are experiencing any of the following symptoms:

	Yes	No
Hot Flashes		
Night Sweats		
Vaginal Dryness		
Mood Swings		
Breast Tenderness		
Sleep Disturbances		
Water Retention		
Dry Skin/Dry Hair		

Please check yes or no if you are experiencing any of the following symptoms, regardless if you are on hormone replacement therapy or not:

	Yes	No
Decreased Desire to Exercise		
Decreased Ability to Exercise		
Fatigue		
Decreased Sense of Well Being		
Increasingly Stressed		
Decreased Memory		
Decreased Ability to Focus		
Increased Loss of Lean Muscle		
Increased Fat Deposits		
Loss of Concentration		
Difficulty Sleeping		
Thinning or Loss of Hair		
Hot Flashes		
Weight Gain		

Weight Loss		
Mood Swings		
Leaky Bladder		
Decreased Interest in Sex		

Please rate on a scale from 1-5 the following with 1 being the worst and 5 being the best:

Mood	1	2	3	4	5
Energy	1	2	3	4	5
Libido	1	2	3	4	5

Signature _____ **Date** _____

Printed Name _____