YOUTHFUL BALANCE
MEDICAL CENTER

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www.youthfulbalance.net

Date:

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:_____

Occupation:_____

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? _____

Check Yes or No for Each

	Personal History? Yes	Personal History? No	Family History? Yes	Family History? No
Heart Failure/Heart Attack				
Atrial Fibrillation (arrhythmia)				
Heart Valve Disorders				
Stent				
Hypertension				
Clotting Disorders				
Stroke				
Anemia				
Thyroid Disease				
Diabetes				
Cholesterol Problems				
Breast Cancer				
Ovarian Cancer				
Uterine Cancer				
Skin Cancer				
Prostate Cancer				
Prostate Problems				
Erectile Dysfunction				
Liver Disease				
Kidney Disease				
Asthma/COPD				
Anxiety				
Depression				
Orthopedic or Muscle Disorders				
Fibromyalgia				
Back Problems				
Gastrointestinal Ulcers				
Arthritis				

For Male Patients Only

History of hormone replacement therapy (HRT)? _____

_____

Any adverse effects from HRT? _____

_____

Are you currently on HRT? _____

If yes, in what form? _____

What is the dosage and frequency? _____

_____

When is the last time you took the above mentioned medication? _____

For Female Patients Only

History of hormone replacement therapy (HRT)? _____

_____

Any adverse effects from HRT? _____

_____

Are you currently on HRT? _____

If yes, in what form? _____

What is the dosage and frequency? _____

_____

When is the last time you took the above mentioned medication? _____

_____

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, regardless of if you are on hormone replacement therapy or not:

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

Frequent UTI's		
Vaginal Laxity		
Difficulty with Orgasm		
Painful Intercourse		
Painful Urination		

For Both Men and Women

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

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		
Pain in Muscles or Joints		
Decreased Interest in Sex		
Inability to Maintain an Erection		

Signature _____ **Date** _____

Printed Name _____