For Office Use:

Date:

WEIGHT:

BP:

HR:

RR:

BMI:

BF:

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Ph: 561-537-0537 Fax: 561-370-6843
www.youthfulbalance.net

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? _____

PAST MEDICAL HISTORY

Please check any that apply.

	Personal History?	Family History?
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		
Autoimmune Disorders		
Other (please explain)		

1st Day of last period _____ Was it normal? _____

Date of last mammogram _____ Was it normal? _____

Date of last pap smear _____ Was is normal? _____

Have you ever had a hysterectomy? _____

If so, total or partial? _____ When? _____

Currently pregnant? _____

Form of contraception, if any? _____

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? _____

Any other history of hormone replacement therapy (HRT)? _____

Any adverse effects from HRT? _____

_____

***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		

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 Orgasm		

If you are interested in weight loss, please list any previous weight loss methods:

_____

_____

Signature _____ **Date** _____

Printed Name _____