

**For Office Use:**

Date:

WEIGHT:

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? \_\_\_\_\_

**PAST MEDICAL HISTORY****Please check any that apply.**

	<b>Personal History?</b>	<b>Family History?</b>
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)		

1<sup>st</sup> Day of last period \_\_\_\_\_ Was it normal? \_\_\_\_\_  
 Date of last mammogram \_\_\_\_\_ Was it normal? \_\_\_\_\_  
 Date of Last Bone Scan \_\_\_\_\_ 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 Breastfeeding? \_\_\_\_\_  
 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
Sleep	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:

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Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name \_\_\_\_\_