For Office Use:

Date:

WEIGHT:

BP:

HR:

RR:

BMI:

BF:

YOUTHFUL BALANCE
MEDICAL CENTER

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Palm Beach Gardens, Fl 33410
Ph: 561-537-0537 Fax: 561-370-6843
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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 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:

____

____

Signature ______________________________ **Date** ____________________

Printed Name ______________________________