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Complete Female Medical History

Name: ________________________________ **DOB:** __________ **Date:** _____________

My Primary Health Concerns:

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My Current Medical Problems:

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Current Medications—Prescription & Non-Prescription (name/dose/reason/for taking)**:**

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Allergies:

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Current Supplements (name and dose):

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Habits:

☐ Coffee _____ cups per day ☐ Tea _____ cups per day ☐ Soda ____ per day

Alcohol: ☐ Never ☐ Rarely ☐ Weekly ☐ Daily ☐ Gotten drunk in the past month? ☐ Yes ☐ No

☐ Beer ☐ Wine ☐ Liquor—number of drinks: ____ Felt the need to stop drinking? ☐ Yes ☐ No

☐ Energy drinks ______ per day ☐Exercise _____ times a week.

☐ Smoke cigarettes or cigars ______ per day ☐ Number of Years _____ ☐ Year Quit Smoking: _____

☐ Recreational Drugs: _________________________

Nutrition

List any diets you have been on during the past 12 months, along with the reason(s) for following it, the benefits or problems you experienced with it, and the reason(s) for stopping any diet:

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Exercises

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Current Sources of Stress

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Miscellaneous

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Hospital Admissions/Surgeries (Females-not including pregnancies):

Year	Illness/Operation	Year	Illness/Operation

Screening Tests:

Screen	Date	Results?	Screen	Date	Results?
Cholesterol/Lipids			Dental Exam		
Blood Sugar			Eye Exam		
Pap Smear			Skin Exam		
Mammogram/Thermogram					
Bone Density					
Colonoscopy					

Immunizations:

Immunization	Date	Immunization	Date	Immunization	Date
Tetanus/Td		Pneumonia		Varicella	
Influenza (FLU)		Hepatitis			

Family History:

Check boxes if a blood relative has suffered any of the following—indicate which relative(s), and give details below:

1. ☐ Anemia	2. ☐ Alcoholism	3. ☐ Alzheimer's	4. ☐ Arthritis
5. ☐ Asthma	6. ☐ Bleeds Easily	7. ☐ Cancer (type) _______________	8. ☐ Diabetes
9. ☐ Epilepsy	10. ☐ Glaucoma	11. ☐ Hay Fever	12. ☐ Heart Disease
13. ☐ Hepatitis	14. ☐ Hypertension	15. ☐ Lipid Disorder	16. ☐ Mental Illness
17. ☐ Osteoporosis	18. ☐ Stroke	19. ☐ Thyroid Diagnosis	20. ☐ Other:

Has your mother had a hip fracture after age 50? ☐ Yes ☐ No

Family History Details (indicate the number above, which relative(s) and explain):

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Females (complete the following section):

Age when you started menstrual periods: _____	Pregnancies: _____
If menopausal, date of your last period: ___________	Abortions: _________
Date of the 1st day of your last period: ____________	Miscarriages: ________
Periods start every _____ days; number of day of flow	Live Births: ______ Age at 1st delivery: ______
Periods: ☐ Regular ☐ Irregular ☐ Pain/Cramps	Did you ever breast feed? ☐ Yes ☐ No
Pain/Bleeding during or after sex: ☐ Yes ☐ No	Birth Control Method: ______

Females—check only those symptoms you currently experience:

	Mental Fogginess		Increase of Breast Size
	Forgetfulness		Water Retention
	Depression		Impatient, Snappy Behavior
	Minor Anxiety		Pelvic Cramps
	Mood Change		Nausea
	Difficulty Falling Asleep		Flabbiness and Muscular Weakness
	Hot Flashes		Loss of Hair
	Night Sweats		Lack of Energy and Stamina
	Temperature Swings		Loss of Coordination and Balance
	Day—long Fatigue		Decreased Sex Drive
	Decreased Sense of Sexuality		Decreased Hair—Armpit, Pubic, Body
	Lessened Self-Image		Harder to Reach Climax
	Dry Eyes, Skin, and Vagina		Sagging Breasts and Loss of Fullness
	Pain with Sexual Activity		Other:

How do/did you feel during different days of the month of your cycle?

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____

How do/did you feel a few days before and during the period?

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____

How do/did you feel from the day of ovulation to the onset of heavy flow?

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____

Did you develop signs of deficiency after starting birth control pills?

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Did you feel miserable, gain weight or did breast size increase after starting birth control pills?

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Did you feel better after starting birth control pills?

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Additional information you would like to share, or to elaborate on previous questions:

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Medical History

Enter **'X'** and indicate age or dates for all questions which have ever applied to you.
'C' for current ongoing problems, providing dates and details

	Decreased Hearing		Abdominal Pain—Chronic
	Ringing in Ear		Gallbladder Trouble
	Ear Infections—Frequent		Jaundice/Hepatitis
	Dizzy Spells		Have Bowel Movement Every _____ day(s)
	Fainting Spells		Frequent: ☐ Constipation ☐ Diarrhea
	Failing Vision		Diverticulosis
	Eye Pain		Crohn's/Colitis
	Double or Blurred Vision		Bloody or Tarry Stools
	Nose Bleeds—Recurrent		Hemorrhoids
	Sinus Trouble		Hernia; type—
	Sore Throats—Frequent		Urination—Overactive Bladder
	Hoarseness—Prolonged		Overnight > than twice
	Dental Problems:		More than 8 times/24 hours
	Floss teeth _____ times per week		Urgency to Urinate
	Hay Fever/Allergies		Decrease in Urinary Force/Flow
	Pneumonia/Pleurisy		Painful Urination
	Bronchitis/Chronic Cough		Urine Leakage with: Exercise/Straining/Cough
	Shortness of Breath: ☐ Exertional ☐ Laying Flat		Blood in Urine
	Asthma/Wheezing		Kidney Stones
	Chest Pain		Urine Infections—Frequent
	Hight Blood Pressure		Sexually transmitted diseases:
	Heart Murmur		Recent Weight—☐ Gain ☐ Loss: lbs.
	Rapid Heart Beat		Desired Weight: lbs.
	Swollen Ankles		Anemia
	Irregular Pulse		Bruise Easily
	Palpitations		Blood Transfusions
	Leg Pain—when walking		Cancer: Type(s)—
	Varicose Veins/ Phlebitis		Chronic Fatigue
	Cold Numb Feet		Diabetes
	Loss of Appetite—Recent		Seizures
	Difficulty Swallowing		Stroke
	Heartburn		Tremor/Hands Shaking

	Peptic Ulcer		Numbness/Tingling Sensations
	Persistent Nausea/Vomiting		Headaches—Frequent
	Bone Fracture/Joint Injury		Arthritis: type/location:
	Fractures after Age 50? ☐ Yes ☐ No		Back Pain—Recurrent
	Foot Pain		☐ Acupuncture ☐ Tattoos
	Osteoporosis		Abuse: ☐ Physical ☐ Sexual ☐ Other
	Gout		Hair Loss: ☐ Progressive ☐ Recent
	Rashes		Do you have a lack of energy?
	Hives		Do you have less strength/endurance?
	Psoriasis		Have you lost height? ______inches
	Eczema		Decreased "enjoyment of life?"
	Sleeping Difficulty		Are you sad and/or grumpy?
	Concentration		Recent deterioration in ability to play sports?
	Depression		Are you falling asleep after dinner?
	Nervousness		Recent deterioration in work performance?
	Agitation		Do you have a decrease in libido?
	Memory loss		Satisfied with orgasm frequency? ☐ Yes ☐ No
	Moodiness		Are you sexually active? Past Current
	Suicidal thoughts		Opposite Sex ☐ ☐
	Phobias		Same Sex ☐ ☐
	Mental Illness		Single Partner ☐ ☐
	Feelings of worthlessness		Multiple Partners ☐ ☐
	Rheumatic Fever		Number of Sex Partners in Past Year: _______
	Scarlet Fever		Mumps
	Chicken Pox		German Measles
	Polio		Tuberculosis
	Mumps		Herpes
	German Measles		Aids/HIV
	Tuberculosis		Thyroid Disease

Patient Signature: ________________________________ **Date:** ______________