

## MEDICAL HISTORY FORM

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
last middle first

Address \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
street

\_\_\_\_\_ Telephone \_\_\_\_\_  
city state zip

Doctor \_\_\_\_\_ Doctor's Telephone \_\_\_\_\_

Allergies	Yes	No	Over-the-counter (OTC) issues: (occasionally or regularly)	Yes	No	Medical Conditions	Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Pain Reliever	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol or lipids	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drug	<input type="checkbox"/>	<input type="checkbox"/>	Acetaminophen (ex: Tylenol®)	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Morphine	<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen (ex: Motrin IB®)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Naproxen (ex: Aleve®)	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Ketoprofen (ex: Orudis KT®)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Dye allergies	<input type="checkbox"/>	<input type="checkbox"/>	Cough suppressant (ex: Robitussin DM®)	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal related issues	<input type="checkbox"/>	<input type="checkbox"/>
Nitrate allergies	<input type="checkbox"/>	<input type="checkbox"/>	Antihistimine product (ex: Chlor-Trimeton®)	<input type="checkbox"/>	<input type="checkbox"/>	Blood clotting problems	<input type="checkbox"/>	<input type="checkbox"/>
No know allergies	<input type="checkbox"/>	<input type="checkbox"/>	Decongestant product (ex: Sudafed®)	<input type="checkbox"/>	<input type="checkbox"/>	Lung condition (Asthma)	<input type="checkbox"/>	<input type="checkbox"/>
Pet allergies	<input type="checkbox"/>	<input type="checkbox"/>	Combination product, cough+cold relieve (ex: Triaminic®)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal (pollen)	<input type="checkbox"/>	<input type="checkbox"/>	Sleep aids (ex: Excedrin PM®, Unisom®, Sominex®)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis or joint problems	<input type="checkbox"/>	<input type="checkbox"/>
other	<input type="checkbox"/>	<input type="checkbox"/>	Antidiarrheals (ex: Imodium®, PeptoBismol®, Kaopectate®)	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
			Laxatives/stool softeners (ex: Doxidan®, Correctol®)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
<b>Used</b>	How often?		Diet aids/weight loss products (ex: Dexatrim®)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	_____		Antacids (ex: Maalox®, Mylanta®)	<input type="checkbox"/>	<input type="checkbox"/>	Eye disease (glaucoma, etc)	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	_____		Acid blockers (ex: Tagamet HB®, Pepcid AC®, Zantac 75®)	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Caffeine	_____		Other: (please list) _____					

### Nutritional/Natural Supplements

	Yes	No	What kind?
Vitamins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Minerals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herbs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Enzymes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nutritional	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Bone Size

Small  Med  Large

### Bone Type

Androgenic  Estrogenic

### Family History

	Yes	No	Family Member
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibrocystic Breasts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Medical History

	Yes	No	Date
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovaries removed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tubal Ligation	<input type="checkbox"/>	<input type="checkbox"/>	_____

  

	Yes	No	How Many?
Pregnancies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	_____

  

	Yes	No	Any problems
Have you used Contraceptives	<input type="checkbox"/>	<input type="checkbox"/>	_____

  

Have you had any of these tests?

	Yes	No	Date
Mammography	<input type="checkbox"/>	<input type="checkbox"/>	_____
PAP Smear	<input type="checkbox"/>	<input type="checkbox"/>	_____

Current Medications	Strength	Date Started	Dosage per day
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____

  

Previous Hormones	Started	Stopped	Reason
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____

### Have you ever had what you consider an abnormal period cycle?

If so, when? \_\_\_\_\_  
 Please explain: \_\_\_\_\_  
 Date of last period \_\_\_\_\_ How long? \_\_\_\_\_

### Do you have or did you ever have PMS?

If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Have you experienced any of the following symptoms recently?

Please check the number that best describes your experiences.

1 = absent, 2 = mild, 3 = moderate, 4 = severe

	1	2	3	4		1	2	3	4
Sleep Disruptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Decreased Libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluid Retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hard to Reach Climax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Recent Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>