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TIER 1
HEALTH AND WELLNESS

HEALTH AND WELLNESS FEMALE CONSULTATION MEDICAL HISTORY

NAME:____ **DATE:**_________________________

ADDRESS:____

PHONE #:______________________________ **E-mail:**__________________________________

DOB:_________________ **Age:**________ **Occupation:** _________________ **Marital Status:**_______

My Primary Health Concerns

Allergies:____

Primary Care Doctor:____ Phone No.:_______________

Pharmacy:____ Phone No.:_______________

Approximate date of: Last complete physical exam: ____

Last pap:_________________________________ Mammogram:____________________

Do you have a history of cancer? If so, what type?_______________ How long ago?_________________

Have you ever had a blood clot or been diagnosed with a blood clotting disorder? ______________________

Current Medications - Prescription and Non-Prescription (name/dose/reason for taking)

Do you smoke?____ How much?_______ How often?_____________ When did you quit?_____________

Do you use alcohol?_________ (Type and how much per week) _________________________________

NAME:____ DATE:_________________________

FAMILY HISTORY

List any serious problems (ex: cancer, diabetes, arthritis, heart disease)
which relative?

Females

Date of last menstrual period:______________________

Have you or a family member ever been diagnosed with PCOS?________

How many children do you have?_________ Have you ever had a miscarriage?_________

Did you have difficulty getting pregnant? _________Have you ever been diagnosed with ovarian cysts?______

Have you experienced difficulty with acne?________Facial or body hair growth?_____________

Have you had a hysterectomy?__________ Was it partial or complete?_________When?______________

Describe current status of menstrual cycles:

Check only those symptoms that you currently experience

	Mental fogginess		Increase of breast size
	Forgetfulness		Water retention
	Depression		Impatient, snappy behavior
	Minor anxiety		Pelvic cramps
	Mood changes		Nausea
	Difficulty falling asleep		Flabbiness and muscular weakness
	Hot flashes		Loss of hair
	Temperature swings		Lack of energy and stamina
	Day long fatigue		Loss of coordination and balance
	Decreased sense of sexuality		Decreased sex drive
	Lessened self image		Decreased hair (armpit, pubic, body)
	Dry eyes, skin, vagina		Harder to reach climax

	Sagging breasts and loss of fullness		Pain with sexual activity
	Weight gain		Decreased muscle strength
	Joint/body aches and pains		Fibromyalgia

Communication Preferences

How do you prefer to be reached?	Best time to reach you?
How did you hear about us?	

Patient signature:____ Date: ______________________

Physician signature:______________________________________ Date: ______________________