TIER 1
HEALTH AND WELLNESS

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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 #:_____

Pharmacy:_____ Phone #:_____

Approximate date of: Last complete physical exam: _____

Women: 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?_____

Have you ever been on hormone replacement therapy?_____

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 Current Symptoms ONLY

Current Symptoms	**None**	**Mild**	**Mod**	**Severe**
Mental fogginess				
Forgetfulness				
Depression				
Minor anxiety				
Mood changes				
Difficulty falling asleep				
Hot flashes				
Temperature swings				
Day long fatigue				
Decreased sense of sexuality				
Lessened self-image				
Dry eyes, skin, vagina				
Sagging breasts and loss of fullness				
Weight gain				
Joint/body aches and pains				

Increase of breast size				
Water retention				
Impatient, snappy behavior				
Pelvic cramps				
Nausea				
Flabbiness and muscular weakness				
Loss of hair				
Lack of energy and stamina				
Loss of coordination and balance				
Decreased sex drive				
Decreased hair (armpit, pubic, body)				
Harder to reach climax				
Pain with sexual activity				
Decreased muscle strength				
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: _____