



618 US Highway One, Suite 200 North Palm Beach, Florida 33408
Phone: 561-844-8188 Fax: 561-844-8142

Women's Health Medical History

Name _____ DOB _____

Email _____ Phone _____ Cell # _____

Date of last menstrual period _____ Birth Control _____

Any problems related to periods/ birth control _____

G _____ P _____ Type of delivery _____ Tubal Ligation _____

If Menopausal: Date of onset _____ Hysterectomy yes _____ no

Use of HRT no yes (please give a detailed history of use) _____

Please list all prescriptive medications currently being taken: _____

Please list all supplements/nutraceuticals: _____

Name _____

DOB _____

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Smoker no yes How many packs per day _____ how long _____ desire to quit no yes

Alcohol use no yes How many drinks per day _____

Caffeine use (includes soda, teas, energy drinks) no yes How many per day/and type _____

Please describe your exercise routine _____

Please describe your dietary habits (include diets for weight loss, success/failures etc.) _____

List all surgeries (including cosmetic) _____

List all medical history (including Thyroid, Blood Pressure, Lipids, and Diabetes)

Date of last Pap smear _____ normal abnormal _____

Date of last Mammogram _____ normal abnormal _____

On the next page please check any symptoms you have had or are having.

Rate them on a scale of: 1=mild 2=moderate 3=severe

Please state comments/concerns regarding any symptoms.

Name _____

DOB _____ pg3

_____ Hot Flashes _____

_____ Night Sweats _____

_____ Vaginal Dryness _____

_____ Loss of Libido _____

_____ Orgasm _____

_____ Skin/Hair Changes _____

_____ Weight Gain/Loss _____

_____ Memory Loss _____

_____ Irritability _____

_____ Difficulty Concentrating _____

_____ Anxiety _____

_____ Depression _____

_____ Insomnia _____

_____ Fatigue _____

_____ Weakness/Joint Aches _____

_____ Headaches _____

_____ Bladder Infections _____

_____ Vaginal Infections _____

_____ Breast Problems _____

_____ Other _____