Medical History Form - Female

Date completed _______________
Name ____ Date of Birth ______________________
Date of last Physical Exam and Pap Smear________________
History of Abnormal Results____
Date of last Mammogram___________ Bone Density Test___________Blood Lipids________________
Colonoscopy________________

What are your immediate concerns today? ____
____

HEALTH HISTORY: Place a √ if you have had any of the following. Immediate family =parents, brothers, sisters.

You	Family	Condition	You	Family	Condition	You	Family	Condition
		heart			diabetes			headaches
		anemia			bowel problems			uterine problems
		stroke			Mental illness			breast problems
		vascular problems			gallbladder			abnormal pap smear
		high cholesterol			eye problems			ovarian problems
		high blood pressure			cancer			pelvic infections
		other blood problems			depression			allergies
		thyroid problems			dizziness/numbness			herpes
		dermatology/skin			joint/bone			neurological problems
		seizures			liver disease			osteoporosis
		surgery			eating disorder			fractures
		lung problems			arthritis			kidney/UTI
		other			autoimmune disease			

Please explain above answers: ____

____

____

Hospitalizations: ____

____

MENSTRUATION/REPRODUCTIVE HISTORY:

First day of last menses _____________ Number of days of bleeding ____________

Number of days from first day of menses to first day of next menses____________

Age of first period ______ Heavy, painful or irregular menses? ____________________________

Pregnancies(#) ________ Births(#) ________ Miscarriages (#) _______ Abortions(#) ________
Vaginal deliveries(#)_______ Cesarean deliveries(#) _______ Complications____________
Age of onset of menopause ___________

Name:________________________________ Date of Birth____________________________

LIST CURRENT:

MEDICATIONS	SUPPLEMENTS	HERBS

LIFESTYLE

Do you smoke? _________ If so, how many cigarettes/cigars a week ____________________

Do you consume alcoholic beverages? __________ If so, how many a week_______________

Any recreational drug use? __________ If so, how frequently? _________________________

Describe your exercise in a typical week _____________________________________

____

Spiritual Practices____

Counseling, chiropractic, acupuncture, or other healthcare providers __________________

____

Please describe 2 days typical food intake. Include water, alcohol and other beverages:

Day 1 Breakfast Lunch Dinner Snacks

Day 2 Breakfast Lunch Dinner Snacks

Name:________________________________ Date of Birth____________________________

Patient Assessment

Hormone Symptoms – Female

Mark each check box for symptoms which are troublesome and persist over time.

Estrogen Deficiency	Estrogen Dominance/Progesterone Deficiency		Progesterone Excess
☐ Hot flashes	☐ Mood swings (PMS)	☐ Hot flashes	☐ Sleepiness
☐ Night sweats	☐ Tender breasts	☐ Night sweats	☐ Mild depression
☐ Vaginal dryness	☐ Water retention	☐ Vaginal dryness	☐ Breast tenderness
☐ Foggy thinking	☐ Nervous	☐ Foggy thinking	☐ Candida
☐ Memory lapses	☐ Irritable	☐ Memory lapses	
☐ Incontinence	☐ Anxious	☐ Incontinence	
☐ Tearful	☐ Fibrocystic breasts	☐ Tearful	
☐ Depressed	☐ Uterine fibroids	☐ Depressed	
☐ Sleep disturbances	☐ Weight gain – hips	☐ Sleep disturbances	
☐ Heart palpitations	☐ Bleeding changes	☐ Heart palpitations	
☐ Bone loss	☐ Headaches	☐ Bone loss	
☐ Headaches	☐ Cold body temperature	☐ Headaches	

Mark each check box for symptoms which are troublesome and persist over time.

Androgen Excess	Androgen Deficiency	
☐ Increased facial hair	☐ Low libido	☐ Sleep disturbances
☐ Increased body hair	☐ Vaginal dryness	☐ Bone loss
☐ Loss of scalp hair	☐ Fatigue	☐ Decreased muscle mass
☐ Acne	☐ Aches/pains	☐ Heart palpitations
☐ Oily skin	☐ Memory lapses	☐ Fibromyalgia
☐ Nervous	☐ Foggy thinking	☐ Irritable
☐ Irritable	☐ Incontinence	☐ Thinning skin
☐ Anxious	☐ Depressed	
☐ Ovarian cysts		
☐ Elevated triglycerides		
☐ Sleep disturbances		
☐ Breast cancer		

Mark each check box for symptoms which are troublesome and persist over time.

Cortisol Excess		Cortisol Deficiency
☐ Sleep disturbances	☐ Heart palpitations	☐ Fatigue
☐ Bone loss	☐ Headaches	☐ Sugar craving
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight gain – waist	☐ Cold body temperature	☐ Chemical sensitivity
☐ Loss of muscle mass	☐ Sugar cravings	☐ Stress
☐ Thinning skin	☐ Low libido	☐ Cold body temperature
☐ Elevated triglycerides	☐ Hair loss	☐ Irritable
☐ Breast cancer	☐ Increased facial hair	☐ Arthritis
☐ Irritable	☐ Increased body hair	☐ Heart palpitations
☐ Anxious	☐ Acne	☐ Aches/pains
☐ Memory lapses	☐ Nervous	
☐ Depressed		