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FEMALE MEDICAL HISTORY *(Please Complete Before Your Visit)*

Contact Information

Name: _____ Preferred First Name (if different): _____
Phone #: _____ *(cell # may be preferred)* OK to leave a message? ___ YES ___ NO
Referred by: _____ Preferred Pharmacy: _____

Health Care Providers (✓CHECK if you would like a note sent to your health care provider)

__ Primary Care: _____ __ Counselor/Therapist: _____
__ Gynecologist: _____ __ Physical Therapist: _____
__ Counselor/Therapist: _____ __ Psychiatrist: _____
__ Other: _____

Demographic Information

Are you (circle all that apply):

Single Married Widowed Committed Relationship Same Sex Relationship

Education:

Less than 12 years High school graduate Currently in school
College Degree Postgraduate degree

What is your profession/what type of work are you doing? _____

Information About Your Condition

What are your primary concerns? _____

How long have you had the issues or concerns? _____

Is there an event associated with the onset of symptoms? ___ No ___ Yes (explain) _____

What medical/nonmedical treatments have you tried? _____

Medical History

How many pregnancies have you had? _____

Resulting in (#): _____ Full 9 months _____ Premature _____ Miscarriage _____ Abortion _____ Living children

Age of children: _____

What is your method of birth control? _____ or N/A

Date of last Pap smear: _____ Date of last Mammogram: _____ or N/A

✓CHECK all that apply:

<input type="checkbox"/> Heavy menstrual flow	<input type="checkbox"/> Hysterectomy/no uterus	<input type="checkbox"/> Pain with wearing tight pants
<input type="checkbox"/> Menstrual cramps	<input type="checkbox"/> Removal of 1 ovary	<input type="checkbox"/> Pain with tampon insertion
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Removal of both ovaries	<input type="checkbox"/> Pain with sexual activity
<input type="checkbox"/> Last period > 1 year ago	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Pain with initial penetration
<input type="checkbox"/> Endometrial ablation	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Pain with deep penetration
<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Burning vaginal pain after sex
<input type="checkbox"/> Recurrent vaginal infections (yeast or bacterial)	<input type="checkbox"/> Vaginal itching	<input type="checkbox"/> Low/absent sexual desire
<input type="checkbox"/> Abnormal Pap smear	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Difficulty with lubrication
<input type="checkbox"/> HPV	<input type="checkbox"/> Vaginal tears (paper cut tears)	<input type="checkbox"/> Never had an orgasm
<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Delayed ability to orgasm

✓CHECK all that apply:

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Back pain / Joint pain
<input type="checkbox"/> Difficulty sleeping	<input type="checkbox"/> Irritable bowel syndrome	<input type="checkbox"/> Osteoporosis / Osteopenia
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Burning with urination	<input type="checkbox"/> Migraines
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Urinary frequency	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Blood clot	<input type="checkbox"/> Frequent UTIs	<input type="checkbox"/> Difficulty focusing
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Interstitial cystitis	<input type="checkbox"/> Irritability
<input type="checkbox"/> Stroke	<input type="checkbox"/> Leakage of urine	<input type="checkbox"/> Attention Deficit Disorder
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Facial hair growth	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Scalp hair thinning	<input type="checkbox"/> Depression
Other cancer _____	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Bipolar disorder

Other medical conditions: _____

Health History

*How often do you exercise? Rarely 1-2 Times weekly 3-5 times weekly Daily

*How many cups of caffeine per day? (include coffee, tea, soda) 0 1-3 4-6 More than 6

*Do you smoke cigarettes? NO YES How many cigarettes per day? _____ For how many years? _____

*How often do you drink alcohol? Never Rarely Monthly Weekly Daily

*Do you use recreational drugs? NO YES

*How would you describe your diet? (circle all that apply)
 Well- Balanced Fried/Fast food Low Fat Low Cholesterol Other: _____

*Do you have issues/concerns with your body image or eating habits? NO YES

*Please list any causes of stress (ex. finances, work, relationship) _____

*Have you ever been the victim of: Verbal abuse Physical abuse Sexual abuse Rape No Answer

ALLERGIES: _____

Current Medications

Medication	Dose/Frequency	Notes

Surgical Procedures

Year	Procedure	Year	Procedure

Family History

✓ Check if you were adopted ____ (Leave BLANK If you do not know your family history).

✓ Check box if a family member has been diagnosed/treated for any of the following:

	Mom	Dad	Brother	Sister	Grandma (mom's parent)	Grandma (dad's parent)	Grandpa (mom's parent)	Grandpa (dad's parent)
Anxiety								
Depression								
Heart Disease								
High Cholesterol								
Stroke								
Breast cancer								
Ovarian cancer								
Prostate cancer								
Uterine cancer								

Additional comments or conditions not listed above: _____
