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Patient Medical History

Name: _____ Age: _____ Date of Birth: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Phone: _____ Alternate Phone: _____ email Address: _____
 Male Female Height: _____ Weight: _____ Have you experienced weight gain? Yes No
 If yes, how much weight? _____ Over how long a period of time? _____
 Primary Care Doctor: _____ Address: _____ Phone: _____
 Do you use tobacco? Yes No If yes, how often? _____ How much? _____
 Do you consume alcohol? Yes No If yes, how often? _____ How much? _____
 Do you consume caffeine? Yes No If yes, how often? _____ How much? _____
 (Coffee, tea, soda)
 Do you exercise regularly? Yes No If yes, how often? _____ What type of exercise do you do? _____
 Are you on a diet plan? Yes No If yes, which one? _____ When did you start the program? _____
 List all surgeries /procedures and dates: _____

FAMILY HISTORY	NO	FAMILY MEMBER(S)	LIVING	DECEASED
Uterine Cancer				
Ovarian Cancer				
Breast Cancer				
Prostate Cancer				
Heart Disease				
Osteoporosis				
Fibrocystic Breast				
Other (any other diseases not listed)				

Please list any disease processes of parents and/or direct siblings and current age or age at death: _____

CURRENT PRESCRIPTION MEDICATIONS

MEDICATION NAME	STRENGTH	DATE STARTED	HOW OFTEN PER DAY

OTC MEDICATIONS – Please list all over the counter medications that you use occasionally and regularly

MEDICATION NAME	STRENGTH	DATE STARTED	HOW OFTEN PER DAY

HORMONES PREVIOUSLY TAKEN

MEDICATION NAME	STRENGTH	DATE STARTED	DATE STOPPED	REASON

Have you used any type of **SYNTHETIC HORMONE REPLACEMENT THERAPY** in the past? YES NO

If YES, which one? Provera Premarin How Long? _____

NATURAL/NUTRITIONAL SUPPLEMENT – Please list all vitamins, herbs, minerals, enzymes, protein supplements and joint supplements

NAME	STRENGTH	DATE STARTED	HOW OFTEN PER DAY

Is there anything that you would like to add to your medical history that we may find pertinent to your health? _____

Patient Signature: _____ Date: _____