Name: Today’s Date:   
 *(Last) (First) (Middle)*

Date of Birth: Age: Occupation:

Home Address:

City: State: Zip:

Home Phone: Cell Phone: Work:

Email Address:

How did you hear about us? ☐ Patient (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Event (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Practitioner (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Pharmacy (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

☐ Social Media (Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ TV (Station:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) ☐ Radio (Station:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

In Case of Emergency Contact: Relationship:

Cell Phone: Home Phone: Work:

Pharmacy Name: Phone:

Address:

Primary Care Physician’s Name: Phone:

Address:

OBGYN Physician’s Name: Phone:

Address:

May we share your clinical information with your PCP/Gyn? ☐ Yes ☐ No

**MEDICAL HISTORY**

Weight: Last Menstrual Period: Hysterectomy? ( ) No ( ) Partial ( ) Full

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

Do you smoke? ( ) Yes ( ) No ( ) Quit How much? How often? Age started?   
Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much? How often? Age started?   
Any known drug allergies: ( ) Yes ( ) No If yes please explain:

Current Medications and dosage:

Nutritional/Vitamin Supplements:

Current Hormone Replacement Therapy: Past HRT:

Surgeries, list all and when:

Other Pertinent Information:

Do you have a family history of? ( ) Heart Disease ( ) Cancer ( ) Diabetes ( ) Other

**Preventative Medical Care:**( ) Medical/GYN Exam in the last year.  
( ) Mammogram in the last 12 months.  
( ) Bone Density in the last 12 months.  
( ) Pelvic ultrasound in the last 12 months.

**High Risk Past Medical/Surgical History:**  
( ) Breast Cancer.  
( ) Uterine Cancer.  
( ) Ovarian Cancer.  
( ) Hysterectomy with removal of ovaries.  
( ) Hysterectomy only.  
( ) Oophorectomy Removal of Ovaries.

**Birth Control Method:**  
( ) Menopause.  
( ) Hysterectomy.  
( ) Tubal Ligation.  
( ) Birth Control Pills.  
( ) Vasectomy.  
( ) Other:

**Medical Illnesses:**( ) High blood pressure.  
( ) Heart bypass.  
( ) High cholesterol.  
( ) Hypertension.  
( ) Heart Disease.  
( ) Stroke and/or heart attack.

( ) Blood clot and/or a pulmonary emboli.  
( ) Arrhythmia.  
( ) Any form of Hepatitis or HIV.  
( ) Lupus or other auto immune disease.  
( ) Fibromyalgia.  
( ) Trouble passing urine or take Flomax or Avodart.  
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).  
( ) Diabetes.  
( ) Thyroid disease.  
( ) Arthritis.  
( ) Depression/anxiety.  
( ) Psychiatric Disorder.  
( ) Cancer Type: Year:

**PRINT NAME SIGNATURE DATE**