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**