Integrative Hormone Specialists

Medical History (Female)

Date:_____

Name: _____ Date of Birth _____ Age _____

Height: _____ Weight: _____

Primary Care Doctor Name: _____ Phone Number:_____
Address:_____

Medical Conditions/Diseases: (Please check all that apply.)

____ Heart Disease
____ High Cholesterol or lipids
____ High blood pressure
____ Cancer
____ Ulcers
____ Thyroid Disease
____ Hormone Related Issues
____ Lung Condition
____ Blood clotting problems
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye Disease
____ Other:_____

Past Surgeries:_____

_____

Have you had any of the following performed:

Bone Density Test	____ Yes	____ No	Date: _____	Results: _____
Mammography	____ Yes	____ No	Date: _____	Results: _____
PAP Smear	____ Yes	____ No	Date: _____	Results: _____
Colonoscopy	____ Yes	____ No	Date: _____	Results: _____

Current Prescription Medications:

Medication Name	Strength	How often per day	Date Started

Over-the-Counter Medications: (Please list all products you use occasionally or regularly.)

_____
_____

Nutritional/Natural Supplements: (Please identify and list all products you are using.)

_____

_____

Allergies:

Medicine:_____

Food:_____

Environmental:_____

Other:_____

OB/Gynecologic:

How many pregnancies have you had? _____ How many children?_____

Any interrupted pregnancies? ____ Yes ____ No

Are you still having menstrual cycles? ____ Yes ____ No

Have you had a hysterectomy? ____ Yes ____ No Date: _____

Have you had your ovaries removed? ____ Yes ____ No Date: _____

When was your last period? _____ How many days did it last? _____

Are (or were) your cycles: ____Regular ____Irregular

Rate your menstrual flow: ____Very Heavy ____Heavy ____Moderate ____Light

Have you had a tubal ligation? ____ Yes ____ No Date: _____

What method of birth control are you using, if any? _____

Do you have a family history of any of the following?

Colon Cancer _____ Family Member(s) _____

Ovarian Cancer _____ Family Member(s) _____

Breast Cancer _____ Family Member(s) _____

Heart Disease _____ Family Member(s) _____

Osteoporosis _____ Family Member(s) _____

Diabetes _____ Family Member(s) _____

Thyroid Disease _____ Family Member(s) _____

Alzheimers Dementia _____ Family Member(s) _____

How much and how often?

Do you use tobacco? ____ Yes ____ No _____

Do you use alcohol? ____ Yes ____ No _____

Do you use caffeine? ____ Yes ____ No _____

Do you use any other drugs? ___Yes ___ No If so, what? _____

Have you ever been physically, emotionally, or sexually abused? _____