Medical History Form (Women)

First Name: _____ Last Name: _____

Do you currently have any of these symptoms? ✓ If you do

☐ Abdominal Pain	☐ Depression	☐ Irregular Heart Beat	☐ Rash
☐ Anxiety	☐ Diarrhea	☐ Joint Pain	☐ Shortness of Breath
☐ Back Pain	☐ Dizziness	☐ Leg Swelling	☐ Sore Throat
☐ Breast Lump	☐ Earache	☐ Menstrual Problems	☐ Swollen Glands
☐ Blood in Urine	☐ Easy Bruising	☐ Mole Changes	☐ Urinary Frequency
☐ Chest Pain	☐ Excessive Thirst	☐ Nasal Congestion	☐ Vaginal Discharge
☐ Chills	☐ Fatigue	☐ Nausea	☐ Vomiting
☐ Constipation	☐ Fever	☐ Numbness	☐ Weight Loss
☐ Cough	☐ Headaches	☐ Pelvic Pain	☐ Wheezing

Please list all previous medical problems: ☐ None

_____

_____

_____

Please list any surgeries or medical procedures that you have had (include dates): ☐ None

_____

_____

_____

Do you have any allergies to medication? ☐ No ☐ Yes (If yes, please list the specific medication(s) and the type of reaction you had): _____

_____

Please list diseases which run in your family (include relationship, e.g. Mother, Father etc.):

_____

How much tobacco do you smoke? ☐ None ☐ under 1 pack/day ☐ 1 pack/day ☐ Over 1pack/day
How much alcohol do you drink? ☐ None ☐ Moderate (1 drink/day or less) ☐ Heavy (over 1 drink/day)

Do you have a substance abuse history? ☐ Yes ☐ No

If yes, please explain: _____

Please list your current medications (include dose and frequency): ☐ None

_____

_____

_____

Check if you are: ☐ Pregnant ☐ Nursing