Medical History & Physical – Female

Patient Name: ____________________________________ **Date:** _____________________

Any known drug/food allergies: ____

Do you have a latex/adhesive tape allergy? ( ) Yes ( ) No Have you ever had any issues with anesthesia? ( ) Yes ( ) No

If yes please explain: ____

Medications Currently Taking: ____

____

____

Nutritional/Vitamin Supplements: ____

Current Hormone Replacement Therapy: ____

Past Hormone Replacement Therapy: ____

Have you been on Accutane within the last 6 mo-1 year (when)? ____

Have you used Retin-A/Retinols (when)? ____

Surgeries, list all and when: ____

____

Other Pertinent Information: ____

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 only
( ) Hysterectomy w/removal of ovaries
( ) Oophorectomy (removal of ovaries)

Birth Control Method:

( ) Menopause. ( ) Hysterectomy.
( ) Tubal Ligation. ( ) Vasectomy.
( ) Birth Control Pills.

Habits:

( ) I smoke cigarettes or cigars ______ per day.
( ) I drink alcoholic beverages ______ per week.
( ) I drink more than 10 alcoholic beverages per week.
( ) I use caffeine ________ a day.

Medical Conditions:

( ) High blood pressure ( ) Arrhythmia
( ) Heart bypass ( ) High cholesterol
( ) Hypertension ( ) Heart Disease
( ) Fibromyalgia ( ) Diabetes
( ) Thyroid disease ( ) Arthritis
( ) Depression/anxiety ( ) Psychiatric Disorder
( ) Stroke and/or heart attack ( ) Pacemaker
( ) Blood clot or pulmonary emboli ( ) Metal Implant
( ) Any form of Hepatitis or HIV ( ) Cold Sores
( ) Shingles
( ) Umbilical hernia
( ) Epilepsy or history of seizures
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Lupus/MS/ALS Other: _________________
( ) Cancer (type): ________________Year: _____________

Social:

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex has suffered.
( ) I haven't been able to have an orgasm.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or complications from your treatment that may be irreversible. The treatments I receive here are voluntary and I release this institution, all employees and contractors from liability and assume full responsibility thereof.

Client Signature: ____ **Date:** ________________________________