FEMALE HEALTH HISTORY

Name	Date of Birth: / /	AGE:	S: ☐ M: ☐ D: ☐

Date of last pap smear:

Any abnormal pap? ☐ Yes ☐ No

Ever had your cervix frozen (cryosurgery)? ☐Yes ☐No

When was the 1st day of your period?

Are periods regular or irregular? ☐ Regular ☐ Irregular

Skip periods? ☐ Yes ☐ No

Painful Periods? ☐ Y ☐ N

Heavy bleeding with your periods? ☐Yes ☐ No

Period pain scale (0=none--10=severe)

Pain during or after intercourse? ☐Yes ☐No

Any problems with having sex? ☐ Yes ☐ No

Do you need contraceptive advice? ☐Yes ☐No

Present form of birth control:

What forms of birth control have you used? ☐Condoms ☐Diaphragm ☐Foam ☐ IUD ☐ Pill ☐ Sponge ☐ Tubal ☐ Vasectomy

Any miscarriages or abortions?

Current weight:

How many children do you have?

Tobacco use? ☐ Yes ☐ No	Packs per week:	Alcohol use? ☐ Yes ☐ No	Drinks per wk:

HISTORY OF THE FOLLOWING CONDITIONS *(CHECK YES OR NO FOR EACH OPTION BELOW)*

Herpes ☐ Yes ☐ No	Tubal/Ovarian ☐ Yes ☐ No
Gonorrhea ☐ Yes ☐ No	Cyclic breast pain? ☐ Yes ☐ No
History of breast lumps/tumors? ☐ Yes ☐ No	Milk or discharge from your breast? ☐ Yes ☐ No
Ever had a mammogram? ☐ Yes ☐ No	Family history of breast cancer? ☐ Yes ☐ No
Urine loss with heavy lifting or coughing? ☐ Yes ☐ No	Date of last mammogram?
Bladder symptoms? *(urgency, frequency, pain)* ☐ Yes ☐ No	Involuntary loss of urine? ☐ Yes ☐ No

Medications? ☐ Yes ☐ No *(If yes, please list below)*	Allergies? ☐ Yes ☐ No *(if yes, please list below)*

Any other Medical history we should know? *(please list below)*	Any surgeries? ☐ Yes ☐ No *(if yes, please list below)*

Have you ever taken Estrogen and/or Testosterone in the past? ☐ Yes ☐ No	How long was your last dose/administration?

If yes, what type? ☐ Cream ☐ Injections ☐ Oral ☐ Estrogen ☐ Testosterone ☐ Pellets

HEALTH DATA

Date of Last Pelvic exam:	Date of last physical:

Name(s) of current physicians and specialist:

Briefly describe your current problem or concerns:

Patient signature:	Date:

MALE HEALTH HISTORY QUESTIONNAIRE

Name	Date of Birth / /	Age	Marital Status S☐ M☐ W☐ D☐ SEP☐

PLEASE RATE THE FOLLOWING QUESTIONS (1 = Rare or mild; 4 = frequent or severe)

Fatigue, tiredness, or loss of energy	1☐ 2☐ 3☐ 4☐	Decrease of physical stamina	1☐ 2☐ 3☐ 4☐
Feelings of depression	1☐ 2☐ 3☐ 4☐	Decrease in libido	1☐ 2☐ 3☐ 4☐
Erection or potency problems	1☐ 2☐ 3☐ 4☐	Loss of early morning erection	1☐ 2☐ 3☐ 4☐
Dry skin on face or hands	1☐ 2☐ 3☐ 4☐	Increase in waist size	1☐ 2☐ 3☐ 4☐
Loss of motivation	1☐ 2☐ 3☐ 4☐	Increase in aches, joint/muscle pains	1☐ 2☐ 3☐ 4☐
Decrease in muscle mass	1☐ 2☐ 3☐ 4☐	Increased irritability or bad temper	1☐ 2☐ 3☐ 4☐

Have you ever been treated for Prostate Cancer? ☐ Yes ☐ No

Have you ever been treated for Testicular Cancer? ☐ Yes ☐ No

Tobacco use? ☐ Yes ☐ No	If yes, packs per wk:	Alcohol use? ☐ Yes ☐ No	Drinks per week:

FAMILY HEALTH HISTORY (*Check yes or no if you, or any of your blood relatives have any of the following*)

Cancer ☐ Yes ☐ NO	If yes, who?
Leukemia ☐ Yes ☐ No	If yes, who?
Diabetes ☐ Yes ☐ No	If yes, who?
High Blood Pressure ☐ Yes ☐ No	If yes, who?

MEDICATIONS? ☐ YES ☐ NO (*If yes, please list below*)

ALLERGIES? ☐ YES ☐ NO (*If yes, list below*)

Any other medical history? ☐ Yes ☐ No (*if yes, please list below*)

Any surgeries? ☐ Yes ☐ No (*if yes, please list below*)

HEALTH DATA

Date of last physical exam: Current weight:	Date of last chest x-ray/EKG:
Name(s) of current physicians and specialty: *(list in blank spaces)*	

Briefly describe your current problem:

Patient's Signature:	Date: