MEDICAL HISTORY FORM (Section-1b)

Symptoms/Past Diagnosis: Please check all that apply

- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Ovarian Cysts
- ☐ Osteoporosis/Osteopenia
- ☐ Uterine Fibroids
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Dry Skin
- ☐ Dry Hair
- ☐ Mood Swings
- ☐ Breast Tenderness
- ☐ Water Retention

Have you ever had a Hysterectomy? ☐ YES / ☐ No If yes, Date: _____ Type: ☐ Partial / ☐ Full

Reason: _____

If no, give date of last menstruation period: _____ Has it changed from its normal cycle? ☐Yes / ☐No

If yes, how has it changed? (Ex. Heavier, lighter, longer, shorter) _____

Tubal ligation: ☐ Yes / ☐ No Date: _____

Please list any prescription hormone medications you have taken, when, and for how long you took them:

Please list any family members that have a history of breast, uterine, ovarian or cervical cancer:

Please provide date and details about any abnormal mammograms you may have had.

Please provide date and details about any abnormal Pap Smear tests you may have had.

How many times have you given birth?	How many miscarriages, if any?

Are you currently pregnant?

Is there anything we didn't ask that you would like us to know?

I understand that this form is an addendum to the Medical History Form [Step A], and that I must complete and sign the Medical History Form before completing this form. By signing, I acknowledge that I have read, understand, and agree to the terms and conditions stated in the Medical History Form.

Signature: _____ Date: _____

PLEASE FAX THE COMPLETED & SIGNED FORM TO (561) 658-6212