OPTIMAL HEALTH MEDICAL INSTITUTE PLLC.
(CONFIDENTIAL FEMALE MEDICAL HISTORY)

FULL LEGAL NAME_____ TODAY'S DATE_____
LAST FIRST MI

ADDRESS_____
STREET

_____
CITY STATE ZIP

DOB_____ AGE_____ SEX_____ HEIGHT_____ WEIGHT_____

HOME #_____ WORK #_____ EXT: _____CELL#_____

PREFERRED CONTACT #: HOME WORK CELL
OCCUPATION_____ F T P T RETIRED

LIVING SITUTATION:
SPOUSE____ ALONE____ PARTNER____ FRIENDS____ PARENTS____ CHILDREN____ OTHER____

MARITIAL STATUS: S M D W
PRIMARY PHYSICIAN_____ PHONE NUMBER_____

OTHER PHYSICIANS CURRENTLY SEEING_____
DENTIST_____ PHONE NUMBER_____

IF YOU HAD A REFERRAL, WHO REFERRED YOU?_____

WHAT ARE YOUR THREE MAIN SYMPTOMS/CONCERNS?	**SINCE WHEN?**
1.	
2.	
3.	

FAMILY HISTORY

HAS YOUR PARENTS, SIBLINGS, OR GRANDPARENTS EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?

	YES	**NO**	**FAMILY MEMBER**
UTERINE CANCER			
OVARIAN CANCER			
FIBERCYSTIC BREAST			
BREAST CANCER			
HEART DISEASE			
OSTEOPOROSIS			

PERSONAL HISTORY

	YES	NO	DATE
HYSTERECTOMY			
OVARIES REMOVED			
TUBAL LIGATION			
	YES	**NO**	**HOW MANY?**
PREGNANCIES			
MISCARRIAGES			
	YES	**NO**	**ANY PROBLEMS?**
HAVE YOU USED CONTRACEPTIVES?			
HAVE YOU HAD ANY OF THESE TESTS?	**YES**	**NO**	**DATE**
MAMMOGRAPHY			
PAP SMEAR			

SURGICAL HISTORY

TYPE	DATE
1.	
2.	
3.	
4.	

HAVE YOU EVER HAD WHAT YOU CONSIDER AN ABNORMAL CYCLE?
IF SO, WHEN?_____
PLEASE EXPLAIN:_____
DATE OF LAST PERIOD:_____ **HOW LONG?**_____
DO YOU HAVE OR DID YOU EVER HAVE PMS?_____
IF YES, PLEASE EXPLAIN_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS RECENTLY? PLEASE CHECK THE NUMBER THAT BEST DESCRIBES YOUR EXPERIENCES.
1=ABSENT 2=MILD 3=MODERATE 4=SEVERE

	1	2	3	4		1	2	3	4
SLEEP DISRUPTIONS					WEIGHT GAIN				
FATIGUE					DECREASED LIBIDO				
VAGINAL DRYNESS					DEPRESSION				
IRRITABILITY					FLUID RETENTION				
NERVOUSNESS					HEADACHES				
BREAST TENDERNESS					NIGHT SWEATS				
HOT FLASHES					HAIR LOSS				
DRY SKIN					HARD TO REACH CLIMAX				
MOOD SWINGS					BLADDER SYMPTOMS				
ARTHRITIS					OTHER:				
LOSS OF RECENT MEMORY					OTHER:				

CURRENT MEDICATIONS	STRENGTH	DATE STARTED	DOSAGE PER DAY
1.			
2.			
3.			
PREVIOUS HORMONES	**STARTED**	**STOPPED**	**REASON**
1.			
2.			
3.			

NUTRITIONAL/ NATURAL SUPPLEMENT

	YES	NO	WHAT KIND?
VITAMINS			
MINERALS			
HERBS			
ENZYMES			
NUTRITIONAL			
OTHER			

MEDICAL CONDITIONS	YES	NO
HEART DISEASE		
HIGH CHOLESTEROL OR LIPIDS		
HIGH BLOOD PRESSURE		
CANCER		
ULCERS		
THYROID DISEASE		
HORMONAL RELATED ISSUES		
BLOOD CLOTTING PROBLEMS		
LUNG CONDITION (ASTHMA)		
DIABETES		
ARTHRITIS OR JOINT PROBLEMS		
DEPRESSION		
EPILEPSY		
HEADACHES/MIGRAINES		
EYE DISEASE (GLAUCOMA, ETC)		
OTHER:		

ALLERGIES	YES	NO
PENICILLIN		
CODEINE		
SULFA DRUGS		
MORPHINE		
ASPIRIN		
FOOD ALLERGIES		
DYE ALLERGIES		
NITRATE ALLERGIES		
NO KNOWN ALLERGIES		
PET ALLERGIES		
SEASONAL (POLLEN)		
OTHER:		

DIETARY RESTRICTIONS/FOOD CRAVINGS/INTOLERANCES:_____

AVERAGE DAILY MEAL CHOICES:

BREAKFAST:_____ LUNCH:_____ DINNER:_____

DO YOU GET ROUTINE EXERCISE?_____ WHAT TYPE?_____ HOW OFTEN?_____

DO YOU USE TOBACCO PRODUCTS?_____ HOW MUCH?_____ HOW LONG?_____

DO YOU USE ALCOHOL PRODUCTS?_____ HOW MUCH?_____ HOW LONG?_____

DO YOU USE CAFFEINE PRODUCTS?_____ HOW MUCH?_____ HOW LONG?_____

DAILY WATER INTAKE:_____ DO YOU DRINK OR BATHE IN WELL WATER?_____

OVER-THE-COUNTER (OTC) ISSUES: (OCCASIONALLY OR REGULARLY)	YES	NO
PAIN RELIEVER		
ASPIRIN		
ACETAMINOPHEN (EX: TYLENOL)		
IBUPROFEN (EX: MOTRIN)		
NAPROXEN (EX: ALEVE)		
KETOPROFEN (EX: ORUDIS KT)		
COUGH SUPPRESSANT (EX: ROBITUSSIN DM)		
ANTIHISTIMINE PRODUCT (EX: CHLOR-TRIMETON)		
DECONGESTANT PRODUCT (EX: SUDAFED)		
COMBINATION PRODUCT COUGH+COLD RELIEF (EX: TRIAMINIC)		
SLEEP AIDS (EX: EXCEDRIN PM, UNISOM, SOMINEX)		
ANTIDIARRHEAS (EX: IMODIUM, PEPTOBISMOL, KAOPECTATE)		
LAXATIVES/ STOOL SOFTNERS (EX: DOXIDAN, CORRECTOL)		
DIET ACIDS/ WEIGHT LOSS PRODUCTS (EX: DEXATRIM)		
ANTACIDS (EX: MAALOX, MYLANTA)		
ACID BLOCKERS (EX: TAGAMENT HB, PEPCID AC, ZANTAC 75)		
OTHER:		

STOP: This section is to be reviewed and completed at OHMI

General Yearly History Update

I have reviewed my Female Medical History form and have marked below accordingly.
All information is correct/up to date _____ Information needs to be corrected/updated_____

Patient name:_____
Patient signature or Guardian and relationship:_____

I have reviewed my Female Medical History form and have marked below accordingly.
All information is correct/up to date _____ Information needs to be corrected/updated_____

Patient name:_____
Patient signature or Guardian and relationship:_____

I have reviewed my Female Medical History form and have marked below accordingly.
All information is correct/up to date _____ Information needs to be corrected/updated_____

Patient name:_____
Patient signature or Guardian and relationship:_____

REV.2/2013