Name ____

REASON FOR VISIT: ____
MEDICAL HISTORY (ex: diabetes, hypertension, cholesterol, obesity…)

_______________ ______________ _______________ ________________ _______________

_______________ ______________ _______________ ________________ _______________

Any of the following? (Circle) herpes HPV chlamydia gonorrhea HIV genital warts
INCONTINENCE: frequency urgency urine leakage stool/gas leakage

PAST SURGICAL HISTORY (ex: hysterectomy, general, plastic surgery, broken bones…)

____________________ ______________________________ _____________________________

____________________ ______________________________ _____________________________

FAMILY HISTORY (M=mother, F= father, S=sibling, MGM, MGF=mother's parents PGM, PGF=father's parents

____________________ ______________________________ _____________________________

____________________ ______________________________ _____________________________

Please describe your skin & other cosmetic concerns by checking all that apply:

___ Acne
___ Fat/Cellulite
___ Double Chin
___ Droopy Eye Lids
___ Facial Redness
___ Fine Lines/Wrinkles
___ Hemorrhoids
___ Lip Lines
___ Saggy Skin
___ Scars
___ Skin Discoloration
___ Skin Tags
___ Stretch Marks
___ Sun Damage
___ Toe Fungus
___ Under Eye Bags
___ Under Eye Dark Circles
___ Unwanted Hair

SOCIAL HISTORY
Smoker: ___yes ___ no; Alcohol: ___yes/social ___ no; Drug usage: ___yes ___ no; Regular exercise: ___yes ___ no

Safety: Household smoke detector ___yes ___no, Firearms in Home ___yes ___no, Wear Seatbelts ___yes ___no

Sexual Activity: ___ yes ___no; Nutritional Supplements: ___________ ___________ __________
Marital Status (Circle): Single Married Divorced Widowed

OB HISTORY
Age of menses ____ Age of menopause ____ History of Hormone Therapy ___yes ___no History of Abnormal Pap ___yes ___ no

Number of Pregnancies ____ full term ____ preterm ____ miscarriage ___ living ___ Infertile ___yes ___no Uterine Bleeding ___yes ___no

Method of Contraception _________ Last Menstrual Period _________

Recent Hospitalizations (within the last year) ____
Immunizations: up to date or unsure

MEDICATION/DOSAGE ______________________________ _______________________________

____________________ ______________________________ _______________________________

DRUG ALLERGIES: ____
I REQUEST THE FOLLOWING TESTS

BLOODWORK STD BLOODWORK BONE DENSITY
STD TESTING MAMMOGRAM PREGNANCY TEST

PHARMACY NAME_______________________________________ZIPCODE__________________________

PHARMACY NUMBER ____________________________________(WE ESCRIPT RX)

WELLNESS CHECKLIST FOR WOMEN

Name: ______________________ **Date:** ______________

E-Mail Address: ______________________

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Depressive mood (Feeling down/sad/lack of drive)				
Memory Loss (Forgetfulness)				
Mental confusion (Feeling in a mental fog)				
Decreased sex drive/libido (Decreased desire for sex)				
Sleep problems (Difficulty falling/staying asleep/wake up tired)				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness Hot				
flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Other symptoms that concern you: