



www.midlandsmedwc.com

Female Hormone Assessment Form

Name: _____

Date of Birth: _____ social security #: _____

Street Address: _____

City: _____ State: _____ zip: _____

Email address: _____

In case of emergency, whom should we notify? _____

Phone number(s): _____

Past Medical History

Do you have any medical problems? (i.e. high blood pressure, diabetes, cholesterol, anemia)

List all surgeries including gyn procedures: _____

Midlands Medical Wellness Center LLC
200 Springtree Dr., suite 200 | Columbia, SC 29223
Phone 803-223-9328

Name: _____ Date of Birth: _____

Last pap smear? _____ Last mammogram? _____ Were either of these abnormal? _____ If yes, how so? _____

Do you have any drug allergies? _____

Please list medicines that you are currently taking including doses and over the counter meds. _____

Do you smoke? ___yes ___no If yes, then how much daily? _____ How many years? _____

Are you: ___married ___single ___divorced ___significant other?

Family History (medical problems of your siblings, parents, grandparents) _____

Please circle if you are experiencing any of the following.

- | | | | |
|--------------|---------------------|-----------------|-------------------|
| Mood changes | bloating | Sleep loss | Joint pain |
| Memory loss | Decreased sex drive | Vaginal dryness | Migraine/headache |
| tension | Weight gain | Hot flashes | fatigue |
| depression | Breast tenderness | Night sweats | Mental confusion |

The information that I supplied is true to the best of my knowledge.

Signature _____ Date _____