Midlands Medical© WELLNESS CENTER

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
7201 Brookfield Rd., 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

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