Female Patient Questionnaire & Medical History

Social:
( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex life has suffered.
( ) I haven't been able to have an orgasm.

Habits:
( ) I smoke cigarettes or cigars_____ a day.
( ) I drink alcoholic beverages_____ per week.
( ) I drink more than 10 alcoholic beverages per week.
( ) I use caffeine_____ a day.

Medical History

Any known drug allergies: _____
Have you ever had any issues with anestheia? ( ) Yes ( ) No
If yes, please explain: _____
Prescription Medications Currently Taking: _____
_____
_____
Current Hormone Replacement Therapy: _____
Past Hormone Replacement Therapy: _____
Nutritional/Vitamin Supplements: _____
_____
Surgical History and Dates: _____
_____
Last menstrual period (estimate year if known): _____
Other Pertinent Information: _____
_____

Preventative Medical Care:
( ) Medical/GYN Exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone Density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy w/removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy(removal of ovaries)

Birth Control Method
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other: _____

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High Cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and /or pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease(hepatitis,
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer (type): _____ Year: _____