NEW AGE HEALTH SOLUTIONS

MEDICAL HISTORY FORM (Women only)

Symptoms/Past Diagnosis: Please check all that apply

- ☐ Fibromyalgia
- ☐ Migraines
- ☐ Ovarian Cysts
- ☐ Osteoporosis/Osteopenia
- ☐ Uterine Fibroids
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Dry Skin
- ☐ Dry Hair
- ☐ Mood Swings
- ☐ Breast Tenderness
- ☐ Water Retention

Have you ever had a Hysterectomy? ☐ YES / ☐ No If yes, Date: ________________ Type: ☐ Partial / ☐ Full

Reason: ____

If no, give date of last menstruation period: ______________ Has it changed from its normal cycle? ☐Yes / ☐No

If yes, how has it changed? (Ex. Heavier, lighter, longer, shorter) ______________________________________

Tubal ligation: ☐ Yes / ☐ No Date: ____

Please list any prescription hormone medications you have taken, when, and for how long you took them:

Please list any family members that have a history of breast, uterine, ovarian or cervical cancer:

Please provide date and details about any abnormal mammograms you may have had.

Please provide date and details about any abnormal Pap Smear tests you may have had.

How many times have you given birth?

How many miscarriages, if any?

Are you currently pregnant?

Is there anything we didn't ask that you would like us to know?

I understand that this form is an addendum to the Medical History Form [Step #1], and that I must complete and sign the Medical History Form before completing this form. By signing, I acknowledge that I have read, understand, and agree to the terms and conditions stated in the Medical History Form.

Signature: ____ Date: ____________________

PLEASE FAX THE COMPLETED AND SIGNED FORM TO 561-767-4401