AGELESS SKIN & HEALTH SOLUTIONS, LLC

Female Health History Summary

Patient Name: _____ DOB: _____ Date: _____

Address: _____ City: _____ St: _____ zip code:_____

Best Contact #: _____ EMAIL: _____

List in Order of Importance what your concerns are:

1. _____
2. _____
3. _____
4. _____
5. _____

Last time you had blood work done and with what physician: _____

_____

Do you currently have a primary care physician? _(yes or no)_ If Yes, Who? _____

Family History:

	Father	**Mother**	**Siblings**	**Grandparents**	**Spouse**	**Children**
Age if Living						
Reason for Death						
Cancer-Type?						
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N
Obesity	Y N	Y N	Y N	Y N	Y N	Y N

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List All Surgeries & Hospitalizations, including date occurred:

1. _____
2. _____
3. _____
4. _____
5. _____

Please Note When & Why You Have Had Each of the Following:

Xrays:_____ MRI/Cat Scans:_____

Ultrasounds: _____ Accidents: _____

TB Test: _____ HCV: _____

HIV: _____ Last Dental Visit: _____

Last Eye Exam: _____ Other: _____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles: D I N Chicken Pox: D I N Mumps: D I N Rubella: D I N

Tetanus: D I N Whooping Cough: D I N Hemophilus (Hib): D I N Hepatitis B: D I N

Rheumatic Fever: D I N HPV: D I N Polio: D I N Small Pox: D I N

Diptheria: D I N Scarlet Fever: D I N Typhoid Fever: D I N Other: _____

Any vaccination reactions: _____

List **Yes** (Y), **No** (N), or **Past** (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day & # years: _____

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day: _____

Soda Pop: Y N P Ounces per day: _____

Alcohol: Y N P How often, type and how much? _____

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P Any Drug Treatment: Y N P

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Medications (Please give full name, dosage, and how long you have been taking the medication)

Name Dose When/How Often What Purpose

_____

_____

_____

_____

Supplements/Vitamins/Herbs

Name Dose When/How Often What Purpose

_____

_____

_____

_____

Review of Systems:

Present Weight: _____ **Weight one year ago**:_____
Height:_____ **Maximum weight and when**: _____
Minimum weight as adult & when: _____ **Ideal Weight**: _____

Any Known Allergies to food, drugs, environment, animals: _____
_____

REGARDING THE NEXT SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P **Fatigue**: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst? _____
If you have fatigue, can you do what you need to during the day? Y N

SKIN			
Rash:	Y N P	**Color Change:**	Y N P
Hives:	Y N P	**Lump:**	Y N P
Psoriasis/eczema:	Y N P	**Itchy:**	Y N P
Dry:	Y N P	**Warts/moles:**	Y N P
Cancer:	Y N P	**Perspiration:**	Y N P
HEAD			
Headache:	Y N P	**Migraine:**	Y N P

Dandruff:	Y N P	**Head Injury:**	Y N P
Oil/dry hair:	Y N P	**Hair loss:**	Y N P
	NOSE		
Frequent Colds:	Y N P	**Nosebleeds:**	Y N P
Congestion:	Y N P	**Post Nasal Drip:**	Y N P
Polyps:	Y N P	**Seasonal Allergies:**	Y N P
	EYES		
Dry/Watery:	Y N P	**Blurry Vision:**	Y N P
Double Vision	Y N P	**Cataracts:**	Y N P
Glaucoma:	Y N P	**Styes:**	Y N P
Strain:	Y N P	**Discharge:**	Y N P
Itchy:	Y N P	**Dark under Eyelid:**	Y N P
Vision Tested	Y N		
	EARS		
Frequent infections:	Y N P	**Loss of Hearing:**	Y N P
Ringing:	Y N P	**Vertigo:**	Y N P
Discharge:	Y N P	**Pain:**	Y N P
Hearing Tested	Y N		
	MOUTH/THROAT		
Canker sores:	Y N P	**Cold sores:**	Y N P
Sore Throat:	Y N P	**Gum disease:**	Y N P
Dentures:	Y N P	**Cavities:**	Y N P
Loss of taste:	Y N P	**Hoarseness:**	Y N P
Strep throat	Y N P	**Speech Impediments**	Y N F
	NECK		
Stiffness:	Y N P	**Swollen Glands:**	Y N P
Full movement:	Y N P	**Tension:**	Y N P
	RESPIRATORY		
Cough:	Y N P	**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P	**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P	**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P	**Asthma:**	Y N P
Wheezing:	Y N P	**Painful breathing:**	Y N P
	CARDIOVASCULAR		
High Blood Pressure:	Y N P	**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P	**Murmurs:**	Y N P
Arrhythmias:	Y N P	**Palpitations:**	Y N P
Edema:	Y N P	**Chest Pain:**	Y N P
	URINARY TRACT		
Incontinence:	Y N P	**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P	**Kidney Stones**	Y N P
Urgency:	Y N P	**Discharge/Blood:**	Y N P
	GASTROINTESTINAL		

Heartburn: Y N P		**Bowel Movement Freq:**	Y N P
Indigestion:	Y N P	**Recent BM Change:**	Y N P
Bloating:	Y N P	**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P	**Hemorrhoids:**	Y N P
Vomiting:	Y N P	**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P	**Liver Disease:**	Y N P
Pancreatitis:	Y N P	**Ulcer**	Y N P
FEMALE GENITALIA			
Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Food cravings:**	Y N P
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Scan:	Y N P	**If Yes, what were results:**	

Please list any birth control used and ages used: _____

_____

_____

MUSCULOSKELETAL			
Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P
NERVOUS			
Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P
Mental/Emotional			
Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

Exercise :

How often do you exercise? _____ What type of exercise? _____

For how long? _____ Hobbies: _____

Sleep :

How long per night? _____If you wake up frequently, what is the reason? _____

Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P

Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

Patient Signature _____ **Date:** _____