medAge
live happier, be healthier, look better

Confidential Medical History - Female

Date: ____________

Name: ______________________ Date of Birth: ______________ Age: ________

Street Address: ____

____

City: ______________________ State: ________ ZIP: ____________

Phone: ______________________ Email: ______________________

Height ________ Weight ________

			If Yes, how often
Do you use tobacco?	____ Yes	____ No	____________________
Do you use alcohol?	____ Yes	____ No	____________________
Do you use caffeine?	____ Yes	____ No	____________________

Please list ALL the doctors that you currently see

Doctors Name	Specialty	Address	Phone

Have you ever seen a medical doctor in any of the following specialties?

(please check any and all that apply)

_____ General Practitioner
_____ Urologist
_____ Orthopedic Surgeon
_____ Ob/Gyn
_____ Cardiologist
_____ Oncologist
_____ Pain Specialist
_____ Other

____

Allergies: Please check any and all that apply:

_____ Penicillin
_____ Codeine
_____ Sulfa drugs
_____ Morphine
_____ Aspirin
_____ Food allergies
_____ Dye allergies
_____ Nitrate allergies
_____ Other
_____ Pet allergies
_____ Seasonal (pollen)
_____ No known allergies

Please describe the allergic reaction to the above allergen:

____

____

____

____

Please check all of the over-the-counter (OTC) products that you occasionally or regularly use.

Occasional Use	Regular Use		Occasional Use	Regular Use	
		Pain Reliever			Combination product, cough + cold reliever (ex: Triaminic®)
____	____	Aspirin	____	____	Sleep aids (ex. Excedrin PM®, Unisom®, Sominex®)
____	____	Acetaminophen (ex. Tylenol®)	____	____	Antidiarrheals (ex. Imodium®, Pepto Bismal®, aopectate®)
____	____	Ibuprofen (ex. Motrin IB®)	____	____	Laxatives/stool softeners (ex. Doxidan®, Correctol®)
____	____	Naproxen (ex. Aleve®)	____	____	Diet aids/weight loss products (ex. Desatrim®)
____	____	Ketoprofen (ex. Orudis KT®)	____	____	Antacids (ex. Maalox®, Mylanta®)
____	____	Cough suppressant (ex. Robitussin DM®)	____	____	Acid blockers (ex. Tagamet HB®, Pepcid AC®, Zantac 75®)
____	____	Antihistamine (ex. Chlor-Trimeton®)	____	____	Other (please list)
____	____	Decongestant (ex. Sudafed®)	____	____	____________
			____	____	____________

Nutritional/Natural Supplements: Please identify and list the products you are using:

____ Vitamins (ex. multiple or single vitamins such as B complex, E, C, beta carotene)
____ Minerals (ex. calcium, magnesium, chromium, colloidal minerals, various single minerals)
____ Herbs (ex. ginseng, ginkgo biloba, echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
____ Enzymes (ex. Digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
____ Nutrition/protein supplements (ex. shark cartilage, protein powders, amino acids, fish oils, etc.)
____ Others (ex. glucosamine, etc. please list) ______________________________

Medical Conditions/Disease – Please check any and all that apply to you

____ Heart disease (ex. congestive heart failure)
____ High cholesterol or lipids (ex. hyperlipidemia
____ High blood pressure (ex. hypertension)
____ Cancer
____ Ulcers (stomach, esophagus)
____ Thyroid disease
____ Hormonal related issues
____ Blood clotting problems
____ Lung condition (ex. asthma, emphysema, COPD)
____ Diabetes
____ Arthritis or joint problems
____ Depression
____ Epilepsy
____ Headaches/migraines
____ Eye disease (glaucoma, etc)
____ Other: Please list

____

____

Please list any surgeries you have had:

____
____
____
____
____

Current Prescription Medications:

Medication	Strength	Date Started	How often per day

Do you use birth control? ________ Yes _______ No _______ Menopausal

If Yes, what? If hormonal, please provide specific name or brand ______________________________

List any hormones that you have previously taken	Date Started	Date Stopped	Reason

How many pregnancies have you had? ____________ How many children? ____________

When was your last menstrual cycle? _____

Have you had a hysterectomy? _____ No _____ Yes Date of Surgery ________________

Ovaries removed? _____ No _____ Yes

Have you had a tubal ligation _____ No _____ Yes Date of Surgery ________________

Do you have a family history of any of the following?

		Family member(s)
Uterine Cancer	____	
Ovarian Cancer	____	
Fibrocystic Breast	____	
Breast Cancer	____	
Heart Disease	____	
Osteoporosis	____	
Diabetes	____	
HTN	____	
Stroke	____	

Depression ____ ________________________________
Anxiety ____ ________________________________
Dementia ____ ________________________________

Have you had any of the following tests performed?

Please check those that apply and note the date of last test.

Test	No	Yes	Date
Mammography	_____ No	_____ Yes	Date: ______________
PAP Smear	_____ No	_____ Yes	Date: ______________
General dental cleaning	_____ No	_____ Yes	Date: ______________
Colonoscopy	_____ No	_____ Yes	Date: ______________
Eye exam by Optometrist or Opthalmologist	_____ No	_____ Yes	Date: ______________
Full skin exam by Dermotologist	_____ No	_____ Yes	Date: ______________
EKG	_____ No	_____ Yes	Date: ______________
Cardiac Stress Test	_____ No	_____ Yes	Date: ______________
Chest X-ray	_____ No	_____ Yes	Date: ______________

Since you first began having periods, have you ever had what you consider to be abnormal cycles?

______ No _____ Yes Date: ______________

Please explain ________________________________

When was your last period? ________________________________

How long did it last ________________________________

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ______ No ______ Yes

If Yes, please explain symptoms: ________________________________

____

Have you experienced any of the following symptoms recently?

Please check the numbered box that best describes your experiences.

1 - Extremely Mild / 10 - Extremely Severe

	1	2	3	4	5	6	7	8	9	10
Sleep Disruptions										
Fatigue										
Vaginal Dryness										
Irritability										
Nervousness										
Breast Tenderness										
Hot Flashes										
Dry Skin										
Mood Swings										
Arthritis										
Loss of Recent Memory										
Weight Gain										
Decreased Sex Drive										

	1	2	3	4	5	6	7	8	9	10
Decreased Sexual Enjoyment										
Depression										
Fluid Retention										
Headaches										
Night Sweats										
Hair Loss										
Hair Loss										
Harder to Reach Climax										
Bladder Symptoms										
Difficulty Concentrating										
Poor Response to Exercise										
Poor Recovery from Exercise										
Other: ______________										
______________										

Do you consider yourself to be under much stress (please explain)?

____

____

____

Please select all the methods you use to relieve tension and/or stress

_____ Read
_____ Listen to music/play music
_____ Smoke cigarettes/pipe
_____ Sleep
_____ Watch television
_____ Cry
_____ Throw things

_____ Meditate
_____ Blow up
_____ Eat
_____ Exercise or walk
_____ Don't think about it
_____ Work/housework
_____ Have an alcoholic drink

_____ Do nothing
_____ Turn to faith/pray
_____ Take a mind altering drug
_____ Go for a drive
_____ Call a friend/relative
_____ Draw/paint
_____ Enjoy a hobby

If you drink alcohol or use illicit drugs on a regular basis, please answer the following:

Have you ever felt you should cut down on your alcohol or drug use? _____ Yes _____ No

Have people annoyed you by criticizing your alcohol or drug use? _____ Yes _____ No

Have you ever felt bad or guilty about your alcohol or drug use? _____ Yes _____ No

Have you ever drank alcohol or used drugs first thing in the morning to calm your nerves or to help you get going to face your day? _____ Yes _____ No

medAge is a proactive, preventative approach to healthcare designed to preserve optimum human function and moderate the process of aging prior to the onset of degenerative aging.

The **medAge** patient evaluation includes extensive medical history, lifestyle assessment, physical examination and laboratory evaluation to establish a personalized proactive treatment plan consisting of proper nutrition, exercise, stress management and appropriate medical intervention.

I have answered the questions regarding my medical history to the best of my knowledge.

I acknowledge and agree that **medAge** will be providing functional medicine and age management services and that **medAge** will not replace my general practitioner, family medicine physician and/or other medical specialists.

By signing below, I acknowledge that I understand the above and I have been adequately informed of the nature, intended purpose and risks associated with **medAge**. I acknowledge that I have been given ample opportunity to ask questions about my health status, my options and **medAge**. I hereby authorize and consent to **medAge**.

Signature: ____