G. DeAn Strobel, MD, PA

Hormonal Balance & Wellness

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Name _____ Birthdate _____Today's date: _____

MEDICAL & FAMILY HISTORY FORM

Do you: Smoke? YES or NO If yes, how many packs per day _____ # Years smoked _____
Drink Alcohol? YES or NO If yes, how many drinks per day? _____
Drink soda/coffee/tea? _____ How many per day? _____
Use artificial sweeteners? _____ How much per day? _____
Do you have problems with milk or dairy products? YES or NO Other foods? _____

List the prescription and over-the-counter medications you are now taking:

_____ _____ _____
_____ _____ _____

List any supplements, herbs or vitamins that you are taking:

_____ _____ _____
_____ _____ _____

Are you interested in weight loss? If so, please list all medications, products that you have tried in the past and how they worked for you. Also, list any special diets or meal plans that you have tried in the past.

_____ _____ _____
_____ _____ _____

List any allergies you have to drugs, food or other items:

_____ _____ _____
_____ _____ _____

Are you currently under medical care for any reasons? If yes, please explain: _____
_____

WOMEN ONLY:

Age when menstrual periods began _____
Are your periods regular? _____ How Often? _____
How many days do your periods last? _____
How many times have you been pregnant? _____
How many children born alive? _____
Are you menopausal? YES or NO If yes, did this occur NATURALLY or SURGICALLY? And at what age? _____

Past Psychiatric/Mental Health Care: YES or NO

Therapist's Name: _____ For How Long and When: _____

List all procedures, operations or surgeries:

Operation/procedure performed	Year	Hospital	Doctor

List all times you have been admitted to a hospital overnight (except for childbirth)

Reason Hospitalized	Year	Hospital	Doctor

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Have you had any of the following illnesses or conditions: (Please check all that apply)

Measles	Diabetes	Typhoid	Chronic constipation/diarrhea
Rubella (German measles)	Goiter/thyroid disease	Malaria	Ulcerative colitis or Crohn's
Chickenpox	Hives	Other tropical diseases	Rheumatoid arthritis
Mumps	Allergies	Hepatitis	Hashimoto's
Whooping cough	Eczema/psoriasis	Venereal disease or sexually transmitted infection	Osteopenia or osteoporosis
Scarlet fever	Mononucleosis	Seizures	Stroke or TIA
Tonsillitis	Rheumatic fever	Meningitis	Blood clots/DVT or pulmonary embolism
Diphtheria	Poliomyelitis	Ear infections	Glaucoma
Asthma	Pleurisy	Heart murmur	Bronchitis
High blood pressure	Low blood pressure	Migraine headaches	Angina or chest pain
Tuberculosis	Heart attack	Infertility	Ulcer
Phlebitis	Kidney stones	Low hormones or low testosterone	Bladder or kidney infection
Depression or anxiety	Heart stent	Heart arrythmia	Cancer

WOMEN ONLY:

Endometriosis	Breast cancer	Uterine cancer	Ovarian cancer
Uterine fibroids	Uterine polyps	Abnormal pap smear	Menstrual migraines
Fibrocystic breast disease	Breast pain	Prior breast biopsy	

MEN ONLY:

Enlarged prostate	Difficulty urinating or emptying bladder completely	Erectile problems	Chronic constipation/diarrhea
Rubella (German measles)	Goiter/thyroid disease	Malaria	Ulcerative colitis or Crohn's

Other serious illnesses: (Please Explain) _____

_____

_____

Please list the date and results (if known and if applicable) of your last:

Bone Density Scan: _____ Date: _____
Mammogram: _____ Date: _____
X-ray: _____ Date: _____
EKG: _____ Date: _____
Blood Count: _____ Date: _____
Cholesterol: _____ Date: _____
Blood chemistry: _____ Date: _____

Date of last examination by a doctor: _____ Doctor _____ Results: _____

_____