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MEDICAL HISTORY

Do you have any known drug allergies? YES ☐ NO ☐ If yes, please specify: _____

Have you ever had any issues with anesthesia? YES ☐ NO ☐ If yes, please specify: _____

Please list your current medications:

DRUG	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Nutritionals/Vitamins/Supplements:

DRUG	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

List surgeries with year performed: _____

MEDICAL ILLNESSES:

- | | | |
|-----------------------------------------------------|------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Trouble passing urine |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Blood clot/pulmonary emboli | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Stroke and/or heart attack | <input type="checkbox"/> Cancer, type and year | <input type="checkbox"/> Chronic liver disease |
| <input type="checkbox"/> Hemochromatosis _____ | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Elevated PSA | <input type="checkbox"/> Thyroid disease | |
| <input type="checkbox"/> Other: _____ | | |

SOCIAL:

- ☐ I am sexually active
- ☐ I want to be sexually active
- ☐ I have completed my family.
- ☐ I have used steroids in the past for athletic purposes.
- ☐ I smoke cigarettes or cigars - _____ per day.
- ☐ I drink alcoholic beverages - _____ per week.
- ☐ I drink more than 10 alcoholic beverages per week.
- ☐ I drink caffeine _____ times per day.

SMOKING STATUS:

- ☐ I never smoked
- ☐ I am an ex-smoker
- ☐ I smoke cigarettes or cigars _____ per day

FEMALE PATIENTS:

PREVENTATIVE MEDICAL CARE:

- ☐ Last known gyn exam: _____
- ☐ Last known mammogram: _____
- ☐ Bone density in the last 12 month: _____
- ☐ Pelvic ultrasound in the last 12 months: _____

HIGH RISK PAST MEDICAL/SURGICAL HISTORY:

- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Hysterectomy only
- ☐ Oophorectomy – removal of the ovaries

Print Name

Signature

Date