



3550 Parkwood Blvd, Bldg B, Suite 110, Frisco, Texas 75034 972-294-5886 – Office 214-407-8137 – Fax

MEDICAL HISTORY

YES

NO

If yes, please specify:

Do you have any known drug allergies?

YES

NO

If yes, please specify:

Have you ever had any issues with anesthesia?

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:

- | | |
|--|---|
| (<input type="checkbox"/>) I am sexually active | (<input type="checkbox"/>) I never smoked |
| (<input type="checkbox"/>) I want to be sexually active | (<input type="checkbox"/>) I am an ex-smoker |
| (<input type="checkbox"/>) I have completed my family. | (<input type="checkbox"/>) I smoke cigarettes or cigars _____ per day |
| (<input type="checkbox"/>) I have used steroids in the past for athletic purposes. | |
| (<input type="checkbox"/>) I smoke cigarettes or cigars - _____ per day. | |
| (<input type="checkbox"/>) I drink alcoholic beverages - _____ per week. | |
| (<input type="checkbox"/>) I drink more than 10 alcoholic beverages per week. | |
| (<input type="checkbox"/>) I drink caffeine _____ times per day. | |

SMOKING STATUS:

FEMALE PATIENTS:

PREVENTATIVE MEDICAL CARE:

- | | |
|---|--|
| (<input type="checkbox"/>) Last known gyn exam: _____ | (<input type="checkbox"/>) Breast Cancer |
| (<input type="checkbox"/>) Last known mammogram: _____ | (<input type="checkbox"/>) Uterine Cancer |
| (<input type="checkbox"/>) Bone density in the last 12 month: _____ | (<input type="checkbox"/>) Ovarian Cancer |
| (<input type="checkbox"/>) Pelvic ultrasound in the last 12 months: _____ | (<input type="checkbox"/>) Hysterectomy only |

HIGH RISK PAST MEDICAL/SURGICAL HISTORY:

- | |
|--|
| (<input type="checkbox"/>) Oophorectomy – removal of the ovaries |
|--|

Print Name

Signature

Date