Jupiter Family Healthcare Anti-Aging and Wellness: FEMALE

NAME: _____ DATE:_____

E-MAIL ADDRESS_____

Women's OB/GYN history:

Date of last Menstrual period:_____

Are your periods regular?_____ Heavy?_____ Length of cycle?_____

# of Pregnancies____ Miscarriages___ Living Children____ Vaginal births____ C-sections___

Are you sexually active? ____ # times a week_____ problems_____

Current use of birth control _____ Methods used in past_____

History of gynecological surgeries _____

Last pap smear _____ Any abnormal paps _____

Last Mammogram _____ Any abnormal Mammograms _____

Last Bone Density _____ Last Pelvic Ultrasound _____

Surgeries: _____

Current Medications including vitamins:

_____

_____

_____

Hormone Therapy used in the past:

_____

_____

_____

_____

Do you exercise? _____ What type? _____

How often? _____

Do you consider yourself a healthy eater? _____

How do you deal with stressors in your life? (ex: yoga, reading, beach)

_____

_____

How often do you drink alcohol? _____ How much? _____

Do you use recreational drugs? _____ What type? _____

Please check all that apply:

	None	Mild	Moderate	Severe
Sleep disturbance				
Anxiety, Nervousness				
Irritability				
Depression/Mood swings				
Hot flashes				
Vaginal Dryness				
Urinary Leakage				
Dry Skin, Hair				
Fatigue				
Concentration Issues				
Loss of libido/orgasm				
Joint pain				
Hair loss				
Bowel issues				
Weight gain				