The Center for Women

Obstetrics & Gynecology

J. Harley Barrow, Jr., M.D. & Amanda G. Thornton, A.P.N.

FEMALE MEDICAL HISTORY FORM

Name: _____Date of Birth: _____ Today's Date: _____

Social History:
( ) I smoke cigarettes/cigars/vape
( ) I am sexually active
( ) I have completed my family

Any known **drug/environmental (i.e. tape/adhesive) allergies:** _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No
If yes, please explain: _____

Medications currently taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual cycle (estimate year if unknown): _____

Other Pertinent Information: _____

PREVENTATIVE MEDICAL CARE:

Date of last pap smear: _____
Was it normal: ( ) YES ( ) NO
Date of last Mammogram: _____
Was it normal: ( ) YES ( ) NO

DO YOU HAVE A HISTORY OF:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) None of the Above

HAVE YOU HAD:
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy (removal of uterus only)
( ) Oophorectomy (removal of ovaries only)

BIRTH CONTROL METHOD
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy

Please mark any **MEDICAL ILLNESSES:**

( ) High blood pressure
( ) High cholesterol
( ) Uterine Fibroids
( ) Polycystic Ovarian Syndrome (PCOS)
( ) Stroke and/or heart attack
( ) Heart Bypass/Heart Disease
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia/Irregular heartbeat
( ) Any form of Hepatitis or HIV
( ) Lupus or other Autoimmune disease
( ) Fibromyalgia
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Seizure Disorder/Epilepsy
( ) Chronic Kidney Disease
( ) Diabetes
( ) Thyroid Disease
( ) Arthritis
( ) Depression/Anxiety
( ) Cancer (type): _____ & Year: _____

628 Hospital Drive, Ste. 2A – Mountain Home, AR 72653
(870) 425-7300 / FAX: (870) 424-4164

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bioTE® CERTIFIED PRACTITIONER

FEMALE SYMPTOM ASSESSMENT CHECKLIST

Name: _____ **Date:** _____

Please mark any symptoms:

	Never	Mild	Moderate	Severe
Fatigue	( )	( )	( )	( )
Memory Loss	( )	( )	( )	( )
Mental Confusion	( )	( )	( )	( )
Decreased Sex Drive or Libido	( )	( )	( )	( )
Sleep Problems	( )	( )	( )	( )
Mood Changes or Irritability	( )	( )	( )	( )
Tension	( )	( )	( )	( )
Migraine or Severe Headaches	( )	( )	( )	( )
Difficult to Climax Sexually	( )	( )	( )	( )
Bloating	( )	( )	( )	( )
Weight Gain	( )	( )	( )	( )
Breast Tenderness	( )	( )	( )	( )
Vaginal Dryness	( )	( )	( )	( )
Hot Flashes	( )	( )	( )	( )
Night Sweats	( )	( )	( )	( )
Dry or Wrinkled Skin	( )	( )	( )	( )
Hair Falling Out	( )	( )	( )	( )
Cold All the Time	( )	( )	( )	( )
Swelling All Over the Body	( )	( )	( )	( )
Joint Pain	( )	( )	( )	( )

Please mark any Family History:

	Yes	**No**
Heart Disease	( )	( )
Diabetes	( )	( )
Osteoporosis	( )	( )
Alzheimer's disease	( )	( )
Breast Cancer	( )	( )

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