

**La Bella Vita Health and  
Wellness**

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**FEMALE CONFIDENTIAL MEDICAL HISTORY**

Welcome to our office. To better help us evaluate you, please complete the following form. If you have any questions, we will be happy to help you. Thank you.

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email \_\_\_\_\_

**How did you hear about us? Please be specific.**

Friend/Family \_\_\_\_\_

Radio-What station were you listening to? \_\_\_\_\_

Physician Office \_\_\_\_\_

Print Ad- Where was the ad? \_\_\_\_\_

Internet- Which Web site? \_\_\_\_\_

TV- What station were you watching? \_\_\_\_\_

**What procedures are you interested in?**

- \_\_\_\_\_ Weight Loss Program
- \_\_\_\_\_ Hormone Replacement

Spouse's Name \_\_\_\_\_

Number of Children: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

List any allergies (and approx. date):

\_\_\_\_\_  
\_\_\_\_\_

List hysterectomy, do you still have one or both ovaries? (circle)

List any medical conditions you are being treated for at this time: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all medications you are taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you use: (circle) tobacco alcohol caffeine

**FAMILY HISTORY**

**EXERCISE**

	Diabetes	Heart	Kidney	Cancer	Little to none: _____
Mother	_____	_____	_____	_____	2-3 times/wk: _____
Father	_____	_____	_____	_____	Daily: _____
Brother's	_____	_____	_____	_____	Cardio: _____
Sister's	_____	_____	_____	_____	Weights: _____

Have you ever taken any hormones of any kind before? Yes No (If yes, please list which hormones and when, include birth control pills.) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When was your last: Mammogram? \_\_\_\_\_ PAP smear: \_\_\_\_\_

Age at onset of periods: \_\_\_\_\_

Since you first began having periods, have you ever had what you would consider abnormal cycles?

Yes No

When was your last menstrual period? \_\_\_\_\_ How many days did it last? \_\_\_\_\_

How long is your typical menstrual cycle? (e.g. 28 days) \_\_\_\_\_ Days

Do you have, or did you ever have PMS (Premenstrual Syndrome)? Yes No

If yes, please explain (such as age when this occurred, symptoms, etc.): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

On a scale of 1 – 10 (10 being severe), what are your stress levels like? \_\_\_\_\_

How long have they been at that level? \_\_\_\_\_

Have you ever had a severely stressful event that affected your well being? Yes No

If yes, please explain (such as age when this occurred, symptoms, etc.): \_\_\_\_\_

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When you gain weight, where do you gain it? \_\_\_\_\_

Do you have a difficult time getting out of bed in the morning? Yes No

Which describes your sleeping patterns best (circle one):

1. I sleep well and awake refreshed.
2. I have a hard time falling asleep, but once I do, I sleep through the night.
3. I fall asleep easily, but wake up during the night and can't go back to sleep easily.
4. Hard time falling asleep AND wake up and can't go back to sleep without difficulty.

Do you get sick easily and often? Yes No

Which do you crave? salty foods sugary foods fatty foods? (circle)

Do you ever get dizzy or lightheaded momentarily when getting up too fast? Yes No

Are you an "emotional eater"? Yes No

How long has it been since you really felt well? \_\_\_\_\_

What are your two major health complaints?

1. \_\_\_\_\_

2. \_\_\_\_\_