Todays Date:________________ Name: ________________________________

Date of birth: _______________Phone Number: _____________________

Date of last menstrual cycle: ________________

Reason for your visit: ______________________

Are you interested in our free Laser Hair Removal consult today after your visit: _ Yes _ No

Have you had the Gardasil Vaccine? ________

Current Medications/ Vitamins/ Supplements __________ See list that I have provided

Date	Medication	Dose

New Hospitalizations or Surgeries

Date	Procedure	Reason

New Medical History and New Allergies

You	Family	History/Allergies

Lifestyle

Questions	Yes	No
Are you sexually active?		
Do you have more than one partner?		
Is intercourse painful to you?		
Do you urinate more frequently than normal?		
Do you have pain or burning when urinating?		
Do you ever leak urine?		
Have you had any changes in bowel habits?		
Do you exercise on a regular basis? If yes, what type?		
Are you currently using any contraception? If yes, what type?		
Is your menstrual cycle normal?		
Do you have any abnormal bleeding?		
Do you perform a monthly breast exam?		

When was your last mammogram?		
Caffeine intake:	Type:	How much a day:
Tobacco Intake:	Type:	How much a day:
Alcohol Intake:	Type:	How much a day:
Non-Prescribed Drugs:	Type:	How much a day: