

Female Patient Information

Name: _____
Last First Middle

Today's date: _____

Date of Birth: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home: _____ Cell: _____

Do you have an e-mail address you can share with us? _____

Patient employed by: _____

Business address: _____

Business phone: _____

Marital status: (please circle) Married Divorced Single Widow Living with significant other

Spouse's name: _____

Spouse's date of birth: _____ Social Security #: _____

Spouse employed by: _____ Business phone: _____

In case of emergency, whom should we notify: _____

Phone numbers: _____

*Is it ok to leave a message with lab work results on your voice-mail: (please circle) Yes No

** What phone number would you like us to call with lab results and/or appointment reminders?

Phone #: _____

*******Payment is due at time of service*******

Payment types accepted: Cash, Check, Visa, Mastercard, & Discover
(Sorry we do not accept American Express)

What is your primary health concern or reason for considering bio-identical hormone replacement therapy? _____

OB / GYN HISTORY

1. Are you sexually active? YES NO
2. Have you been sexually active? YES NO
3. Do you have pain with intercourse? YES NO
4. Are you now or have you in the past used contraception? YES NO
If yes, what form: _____
5. Date of last pap smear: _____
6. Have you ever had abnormal pap smear? YES NO
If yes, how was it treated? Please check below:
 Repeated Pap Smear Colposcopy Laser Surgery Cone Biopsy
 Cryosurgery (freezing) Hysterectomy Loop Incision
7. Have you had a mammogram? YES NO
If yes, was it normal? YES NO
Date of last mammogram: _____
8. Do you have any breast lumps, tenderness or discharge? YES NO
9. Do you have any PMS symptoms? YES NO
If yes, any treatment? _____
10. Do you have any hot flashes or menopausal symptoms? YES NO
11. Do you have any uterine anomalies? YES NO
12. If you no longer have periods, please state reason: _____
13. Are your periods regular? YES NO
14. Do you have any bleeding between periods? YES NO
15. Do you have any cramping with your periods? YES NO
If yes, circle one: mild moderate severe
16. Medicine taken for cramps? _____
17. Do you have problems leaking urine? YES NO
18. Do you have:
 Fatigue? YES NO
 Decrease of memory? YES NO

Decrease of energy level?

YES NO

Decrease of sexual drive?

YES NO

19. Do you suffer from:

Anxiety?

YES NO

Irritability?

YES NO

Mood swings?

YES NO

Migraines?

YES NO

20. How have you dealt with these symptoms?

21. Is your sex drive the same as it was five years ago?

YES NO

Describe: _____

22. List any other sexual dysfunctions:

23. Have you experienced weight gain in the last one-two years?

YES NO

If yes, please describe: _____

24. Have you lost greater than 10 pounds in less than a month?

YES NO

If yes, why? _____

25. List current medications:

26. How often does your doctor recommend that you have a Pap smear?

27. How often does your doctor recommend that you have a mammogram?

PAST MEDICAL HISTORY

1. Do you have diabetes? YES NO
2. Do you have/had hypertension? YES NO
3. Do you have heart disease? YES NO
4. Do you have a heart murmur? YES NO
5. Do you have/had kidney disease? YES NO
6. Have you ever been treated for psychiatric problems? YES NO
7. Have you ever had rheumatic fever? YES NO
8. Do you have mitral valve prolapse? YES NO
9. Have you ever had a urinary tract infection? YES NO
10. Have you ever had hepatitis/liver disease? YES NO
11. Have you ever had varicosities/phlebitis? YES NO
12. Do you have any thyroid problems? YES NO
13. Have you had any major accidents? YES NO
14. Have you ever had any blood transfusions? YES NO
15. Do you have asthma/lung disease? YES NO
16. Do you have lupus, Scleroderma or similar diseases? YES NO

If yes, please describe: _____

17. Do you have arthritis? YES NO

If yes, what type: _____

18. Do you have any Drug Allergies? YES NO

If yes, please list: _____

19. List any surgeries:

20. List any other operations/hospitalizations (include year & reason):

21. Have you had any anesthesia complications? YES NO

If yes, please list: _____

22. Have you ever been anemic? YES NO

23. Do you have an Internist or Family Doctor? YES NO
If yes, please list name, phone number: _____

24. Have you had your cholesterol checked? YES NO
If yes, date last checked _____
Was it normal? YES NO

SOCIAL HISTORY

1. Do you smoke cigarettes? YES NO
If yes, number per day? _____ Number of years? _____

2. Do you drink alcohol? YES NO
If yes, how much per day? _____

FAMILY HISTORY

1. Do you have a family history of breast cancer? YES NO
If yes, whom? _____

2. Do you have a family history of colon cancer? YES NO
If yes, whom? _____

3. Do you have a family history of ovarian cancer? YES NO
If yes, whom? _____

4. Do you have a family history of osteoporosis? YES NO
If yes, whom? _____

5. Do you have a family history of diabetes? YES NO
If yes, whom? _____

6. Do you have a family history of hypertension? YES NO
If yes, whom? _____

7. Do you have a family history of heart disease? YES NO
If yes, whom? _____

8. Do you have a family history of kidney disease? YES NO
If yes, whom? _____

Purposely Left Blank

Hormone Imbalance Checklist

Name: _____ Date: _____

New Patients: Please indicate current symptoms with an X.

Follow-up Patients: Please indicate changes in your symptoms since your initial visit. Use a scale of 0 - 10, with 10 meaning there has been no change in symptoms and 0 meaning symptom has completely been relieved.

- | | | |
|--------------------------------|----------------------------------|---------------------------------|
| _____ Burned-out feeling | _____ Weight gain in waist | _____ Irregular Menstruation |
| _____ Foggy thinking | _____ Inability to lose weight | _____ Vaginal Dryness |
| _____ Anxiety | _____ Hot flashes | _____ Decreased libido |
| _____ Stress | _____ Night sweats | _____ Erectile dysfunction |
| _____ Lack of motivation | _____ Sleep disturbances | _____ Prostate problems |
| _____ Apathy | _____ Oily skin | _____ Increased urinary urge |
| _____ Depression | _____ Decreased stamina | _____ Infertility problems |
| _____ Irritability | _____ Aches and pains | _____ Decreased urine flow |
| _____ Morning fatigue | _____ Elevated triglycerides | _____ Blood sugar imbalance |
| _____ Evening fatigue | _____ Decreased muscle mass | _____ Cold body temperature |
| _____ General fatigue | _____ Bone loss | _____ Headaches |
| _____ Chronic illness | _____ Elevated cholesterol | _____ Susceptible to infections |
| _____ Autoimmune illness | _____ Decreased mental sharpness | _____ Fibromyalgia |
| _____ Other: please list _____ | | |