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*New Patient History (female)*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Patient History**  
(check all that apply)

- Fatigue and Lack of Energy
- Decreased or absent sex drive (Low Libido)
- Infrequent or absent orgasms
- I feel hopeless and without motivation
- PMS (premenstrual symptoms)
- Dry and wrinkled skin
- Hot Flashes or Night Sweats
- Insomnia
- Changes in mood: anxiety and/or depression
- Weight gain
- New Migraine Headaches
- Dry Eyes
- Declining mental ability and memory
- Diminished strength and exercise tolerance
- Muscle shrinkage, loss of muscle tone
- Joints ache and/or new onset of arthritis symptoms
- Osteoporosis, osteopenia or loss of height
- Other \_\_\_\_\_

**Medical History**

**Allergies to Medicines:** \_\_\_\_\_

\_\_\_\_\_

**Current Medications:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Preventive Medical Care (when)**

- Medical/GYN Exam in the Last Year \_\_\_\_\_
- Mammogram in last 12 months \_\_\_\_\_
- Bone Density in last 12 months \_\_\_\_\_
- Pelvic Ultrasound in last 12 months \_\_\_\_\_

*New Patient History (page 2)*

**Past Medical and Hysterectomy History:**

- Breast Cancer
- Uterine Cancer
- Ovarian Cancer
- Hysterectomy with removal of ovaries
- Hysterectomy only, still have one or both ovaries
- Blood clot or Pulmonary Embolism

**Other Medical Illnesses:**

- Diabetes
- High blood pressure
- Heart bypass surgery or stents
- Thyroid disease
- High cholesterol
- Depression or anxiety
- Fibromyalgia or Chronic Fatigue Syndrome
- Cancer not listed above (type): \_\_\_\_\_ Year: \_\_\_\_\_
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

**Past Surgical History:**  None  Yes (please specify below)

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____

**Birth Control Method:**

(Must be menopausal, have had hysterectomy or use reliable birth control to be on pellet therapy)

- Menopause
- Hysterectomy
- Birth Control Pills
- Tubal Ligation
- Vasectomy (my monogamous committed partner)
- Other: \_\_\_\_\_

**Social:**

- I have completed my family
- I want to be sexually active
- I am married or in a committed relationship (with male or female): \_\_\_\_\_
- I am sexually active (with male, female, or both): \_\_\_\_\_

*New Patient History (page 3)*

**Habits:**

- I smoke cigarettes
- I drink more than 10 drinks of alcohol per week
- I am a recovering alcoholic or substance abuser
- I use or have used marijuana in the past year
- I use or have used cocaine or other illegal drugs in the past year

**Forms of Hormone Replacement I have used and results:**

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**Other problems or concerns not listed in this questionnaire:**

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**Your Goals:**

- I am here for Hormone Pellet Therapy
- I would like to know more about other forms of Bio-identical hormone replacement
- Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Note: Pasadena Pellet Therapy, Inc., A Medical Corporation, is not a practice of, nor in any way affiliated with, Cedars-Sinai Medical Care Foundation.