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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:

_____

_____

_____

_____

Other problems or concerns not listed in this questionnaire:

_____

_____

_____

_____

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 _____