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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 _____