



FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

May we contact you via E-Mail? () YES () NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Marital Status {check one}: () Married () Divorced () Widow () Living with Partner () Single

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance: _____

ID#: _____ Group#: _____

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Social:

- I am sexually active.
- I want to be sexually active.
- I have completed my family.
- My sex has suffered.
- I haven't been able to have an orgasm.

Habits:

- I smoke cigarettes or cigars _____ per day.
- I drink alcoholic beverages _____ per week.
- I drink more than 10 alcoholic beverages a week.
- I use caffeine _____ a day.

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FEMALE PATIENT MEDICAL HISTORY

Surgeries, list all and when: _____

Any known drug allergies: _____

Have you ever had any issues with anesthesia? () Yes () No

If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

- () MedicaI/GYN Exam in the last year
- () Mammogram in the last 12 months
- () Bone Density in the last 12 months
- () Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:

- () Breast Cancer
- () Uterine Cancer
- () Ovarian Cancer
- () Hysterectomy with removal of ovaries
- () Hysterectomy only
- () Oophorectomy - removal of ovaries

Birth Control Method:

- () Menopause
- () Hysterectomy
- () Tubal Ligation
- () Birth Control Pills
- () Vasectomy
- () Other: _____

Medical Illnesses:

- () High blood pressure
- () Heart bypass
- () High cholesterol
- () Hypertension
- () Heart Disease
- () Stroke and/or heart attack
- () Blood clot and/or a pulmonary emboli
- () Arrhythmia
- () Any form of Hepatitis or HIV
- () Lupus or other auto immune disease.
- () Fibromyalgia
- () Trouble passing urine or take Flomax or Avodart
- () Chronic liver disease (hepatitis, fatty liver, cirrhosis)
- () Diabetes
- () Thyroid disease
- () Arthritis
- () Depression/anxiety
- () Psychiatric Disorder
- () Cancer (type): _____ Year: _____

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BHRT CHECKLIST FOR WOMEN

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark):	Never	Mild	Moderate	Severe
Depressive Mood				
Memory Loss				
Mental Confusion				
Decreased Sex Drive/Libido				
Sleep Problems				
Mood Changes/Irritability				
Tension				
Migraine/Severe Headaches				
Difficult to Climax Sexually				
Bloating				
Weight Gain				
Breast Tenderness				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling All Over the Body				
Joint Pain				

Family History	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

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