NEW PATIENT QUESTIONNAIRE

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

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? ☐Electronic ☐Paper

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

Do you have a <u>personal</u> history of? **Check all that apply.**

Preventative Medical Care:
( ) Medical/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
( ) Prostate Cancer

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:_____

_____ _____ _____
PRINT NAME **SIGNATURE** **DATE**

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1.	**Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2.	**Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3.	**Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5.	**Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6.	**Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7.	**Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8.	**Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9.	**Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10.	**Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11.	**Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

_____

_____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?

_____

_____

FOR OFFICE USE ONLY

CHART ID:_____ **DOB:**_____ **APPT DATE:**_____

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