Female Initial Intake Form

Name	**Date of Birth**	**Age**
Street Address	**City, State, Zip Code**	**Best Phone to Reach You**
Cell Phone	**Can We Leave A Message? (yes or no)**	**Email**
Employer	**Occupation**	**Spouse / Partner**
Emergency Contact/Phone	**Primary Care Physician**	**Referred By**

Medical and Family History	**Self**	**Family**		**Self**	**Family**		**Self**	**Family**
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder Disease/ Stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular Heart Rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpitations			Arthritis		
Obesity/Overweight			Heart Valve Disorder			Gout		
Diabetes Mellitus (DM)			Heart Failure			Osteopenia or Osteoporosis		
High Blood Sugar			High Blood Pressure			Kidney Disease or Stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Eating Disorder		
Other:			Cancer Type:			Other Psychiatric Illness		

ALLERGIES List all allergies to medications and reactions.

Medication	Reaction

Latex Allergy ( ) No ( ) Yes

CURRENT MEDICATIONS

Name of Medication	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

CURRENT SUPPLEMENTS (Vitamins, Minerals, Herbs, etc.)

Name of Supplement	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

PREVIOUS SURGERIES

Surgery / Procedure	Date

MEDICAL CARE	DATE	RESULTS OR FINDINGS
Physical Exam		
Gynecological Exam		
Bone Density		
Colonoscopy		
Mammography		
Cardiac Test (EKG, Echo, Stress, etc.)		

DIET AND LIFESTYLE

List dietary restrictions or food allergies:

_____

_____

Describe typical meals:	
Breakfast	
Lunch	
Dinner	
Snacks	

HABITS	Yes	No	Amount / Type
Do you get regular exercise?			
Do you consume alcohol?			
Do you smoke?			
Experience excessive stress?			

GYNECOLOGICAL HISTORY

Age Started Menstruation: _____ Date of Last Menstrual Cycle: _____
Age Stopped if Post-Menopausal: _____
Have you had a hysterectomy? Yes: ____ No: _____ If so, when? _____
Reason: _____
Do you have ovaries: Yes:_____ No:_____ Are your periods regular? Yes: _____ No: ____
How many days do your cycles last? _____
Are your cycles heavy? Yes: ____ No: ____ Bleeding between periods? Yes: _____ No: ____
Endometriosis? Yes: _____ No: _____
Do you have menstrual cramps? Yes:_____ No_____ If so, are they mild? ____ severe? ____
Number of Pregnancies: _____ Number of Children: _____
Have you had a miscarriage Yes: _____ No: _____ If yes, how many? _____
Do you PMS symptoms? Yes: _____ No: _____ If yes, how many days do symptoms last? ___

HORMONE USAGE

Do you take hormones of any kind? Yes_____ No_____ If so, list (include birth control pills, HRT, or natural hormone (s):

Brand	Dose	How Often	Date Started

If you are currently taking hormones, what specific symptoms are improved? Please list:

_____

_____

If you are currently taking hormones, are you experiencing any unwanted side effects? Please list:

_____

Are you familiar with bioidentical hormones? Yes_____ No_____

Have you tried other hormones? Yes: _____ No: _____ If yes, list below:

Brand	Dose	How Often	Date Started	Reason Stopped

Other Information and Concerns	Yes	No
Are you interested in more information about weight loss?		
Are you interested in weight loss medication or programs?		
Are you interested in information about anti-aging skin care?		
Have you ever considered having Botox?		
Are you interested in physician recommended supplements for women's health?		
Are you interested in supplements for various other health concerns?		
Would you like information on men's health to take to your family members or friends?		
Are you interested in lab testing that identifies vitamin deficiencies?		
Would you be interested in inviting your physician to your company or business organization for a presentation on women's health?		
Would you like more information on our concierge program?		
Are there other health concerns that you want to discuss with your physician? Feel free to list here:		

HORMONE RELATED SYMPTOMS
Current Symptoms –mark severity of symptoms that apply to you.

Symptom	Mild	Moderate	Severe
Hot Flashes			
Night Sweats			
Vaginal Dryness			
Painful Intercourse			
Incontinence			
Foggy Thinking			
Tearfulness			
Depression			
Heart Palpitations			
Bone Loss			
Sleep Disturbances			
Headaches			
Aches and Pains			
Fibromyalgia			
Morning Fatigue			
Afternoon Fatigue			
Allergies			
Chemical Sensitivities			
Sugar Cravings			
Salty Cravings			
Weight gain- waist			
Decreased Libido			
Loss of Scalp Hair			
Increased Face or Body Hair			
Cystic Ovaries			
Acne			
Mood Swings			
Breast Tenderness			
PMS			
Bleeding Changes			
Nervousness			
Irritability			
Anxiousness			
Water Retention			
Fibrocystic Breasts			
Uterine Fibroids			
Weight Gain - Hips			
Decreased Stamina			
Decreased Muscle Size			
Rapid Aging			
High Cholesterol			
Puffy Eyes / Face			
Slow Pulse			
Decreased Sweating			
Hair Dry or Brittle			
Nails Breaking /Brittle			
Thinning Skin			
Infertility			
Constipation			
Rapid Heart Beat			
Goiter			
Hoarseness			
Increased Urinary Urge			
Low Blood Sugar			
High Blood Pressure			
Low Blood Pressure			
Numbness – Feet / Hands			