**FEMALE PATIENT INFORMATION**

To help us serve you better, please take a moment to complete this information.

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MI: \_\_\_\_\_ Nick Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P.O. Boxes are insufficient for ordering pellets, please use mailing address.

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_

Email address **(Please Print Legibly):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**YOUR EMAIL ADDRESS IS OUR PREFERRED MEANS OF CONTACTING YOU**

Home Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred phone number for contact: □ Home □ Cell □ Work

May we send you an email for appointment reminder information? □ Yes □ No

 …for medical or additional scheduling information? □ Yes □ No

 …for notifying you of our monthly specials? □ Yes □ No

May we send you regular mail? □ Yes □ No

**Marital Status**:

□ MARRIED □ DIVORCED □ SINGLE or NEVER MARRIED

□ WIDOW □ LIVING WITH SIGNIFICANT OTHER

**Ethnicity**: □ Hispanic □ Asian □ Not Hispanic or Asian

**Language**: □ English □ Spanish □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In case of an **emergency**, whom should we notify?

Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we release **medical or appointment information** to?

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number (if available): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Lab**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number (if available): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear of us? (**Please check all that apply):

 □ Internet □ Magazine □ Newspaper

 □ Billboard □ Mailer □ Staff Member

 □ Friend or Client \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We are honored that you have chosen Allura Skin, Laser, and Wellness Center.**

**Please state the reasons for your visit:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History**

**Weight**: \_\_\_\_\_\_\_\_\_\_\_ **Height**: \_\_\_\_\_\_\_\_\_\_\_\_

**Drug Allergies**: □ NO □ YES List allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescribed medications** that you are currently taking and the dosage amount for each one:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the **vitamins, supplements, and herbs** that you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take Aspirin or other anti-inflammatory medications daily? □ Yes □ No

Are you currently taking Accutane? □ Yes □ No

Have you ever been tested for **HIV**? □ Yes □ No

 If yes, results were □ Negative □ Positive

Have you been diagnosed with **Hepatitis?** □ Yes □ No

 If yes, please check which type:

□ Hepatitis A □ Hepatitis B □ Hepatitis C □ Other

**Habits:**

Do you smoke? □ Yes □ No

 Age that you started smoking: \_\_\_\_\_

 Number of cigarettes per day: \_\_\_\_\_

Do you drink alcohol? □ Yes □ No

 On the average, how many drinks per week? \_\_\_\_\_\_\_\_

Do you use recreational drugs? □ Yes □ No

How often do you exercise? □ Daily □ 0-2 times per week □ 3-5 times per week

**Skin Care History:**

What types of **skin care products or product line(s)** are you currently using?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sensitive to skin care products? □ NO □ YES

 If yes, is sensitivity due to: □ Fragrances □ Irritation □ Rash □ Dryness

In your opinion, what **type of skin** do you have?

 □ Dry □ Normal to Dry □ Normal □ Normal to Oily □ Oily Problem/blemished

**How easy is it to** **tan your skin**?

□ Always burn □ Burn at first, but can get a light tan □ Rarely burn, always tan

□ Never burn, easily tan □ Always tan

Have you been treated for **acne with** □ **oral medications,** □ **creams, or** □ **Accutane**?

Have you ever had any of the following **procedures** (please check all that apply)?

Please include approximate year:

□ Body Contouring (Thermage, VaserShape, or Other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Botox/Dysport/Xeomin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Chemical Peel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Facials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Fillers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Fractional Lasers (Fraxel or CO2 or Sublative or Other):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Hair Removal (Electrolysis, Wax or Dermablading): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ IPL (intense pulse light) or FotoFacial: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Laser Hair Removal: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Microderms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Permanent Make-Up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Skin Tightening of Face or Eyes (Thermage or Other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Teeth Whitening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Vein Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any **adverse reactions** to any of the treatments listed above? □ NO □ YES

If yes, please explain the reactions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please mark all that apply:**

□ Active acne □ Age Spots//Brown spots □ Allergies

□ Anemia □ Anxiety □ Arthritis

□ Asthma □ Atypical Moles □ Augmentation of Breasts

□ Bladder Infections □ Bleeding Disorders □ Blood Cancers

□ Blood clots □ Blood Transfusions □ Breast Reduction

□ Celiac Disease □ Chronic pain □ Cold sores

□ Colon CA □ Colon Polyps □ Cosmetic surgery

□ Crohn’s Disease □ Degenerative Disc Disease □ Depression

□ Diabetes □ Eating Disorder □ Eczema/psoriasis

□ Emphysema/COPD □ Facial hair growth □ Facial Veins

□ Fibrocystic breasts □ Fibromyalgia □ Gluten Intolerance

□ Goiter □ Hair Loss □ Hair Thinning

□ Hashimoto’s □ Headaches/Migraines □ Heart Attack

□ High Cholesterol □ History of skin cancer □ Hyperthyroid/Graves’

□ Hypertension □ Hypothyroid □ Irregular heart rate

□ Irritable Bowel Syndrome □ Keloid scarring □ Kidney Stones

□ Lactose Intolerance □ Leg Veins □ Lung Cancer

□ Lupus Arthritis □ Metabolic Syndrome □ Multiple Sclerosis

□ Murmur □ Osteopenia/osteoporosis □ Reflux

□ Rheumatoid Arthritis □ Rosacea □ Scars

□ Scleroderma □ Sleep Apnea □ Stretch Marks

□ Stroke □ Sun-damaged skin □ Thyroid Cancer

□ Thyroid Nodule □ TIA □ Varicose veins

□ Ulcers

□ Other illnesses not listed above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:**

List all **major surgeries**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list **outpatient procedures, surgeries and hospitalizations** (including year and reason):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any major accidents: □ Yes □ No

**Family Medical History:**

□ Alcohol or Drug Abuse □ Bladder Cancer □ Breast Cancer

□ Celiac Disease □ Cervical Cancer □ Colon Cancer

□ Dementia □ Depression □ Diabetes

□ Heart Disease/MI □ Hereditary Blood Disorders □ High Cholesterol

□ Hypertension □ Lung Cancer □ Lupus

□ Osteoporosis/Osteopenia □ Ovarian Cancer □ Parkinson’s Disorders

□ Psychiatric Disorders □ Prostate Cancer □ Rheumatoid Arthritis

□ Skin Cancers □ Stroke □ Suicide

□ Thyroid Cancer □ Thyroid Disease □ Uterine Cancer

Other illnesses or disease not listed:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorizations:**

I consent to the taking of photographs for the purpose of documentation and future comparison.

Initial \_\_\_\_\_\_\_\_\_

I authorize the release of information to/from my primary care physician or specialist if deemed necessary for the treatment.

Initial \_\_\_\_\_\_\_\_\_

I understand that **my insurance company will not cover any of the procedures performed**.

Initial \_\_\_\_\_\_\_\_\_

Payments for all procedures or services are to be paid at the conclusion of each visit.

Initial \_\_\_\_\_\_\_\_\_\_

I understand that procedure packages are non-transferable.

Initial \_\_\_\_\_\_\_\_\_\_

I authorize that the above information is up to date and correct to the best of my knowledge.

Initial \_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Please complete the remaining pages for your**

**Bio-Identical Hormone Replacement Therapy Consultation and Insertion**

**Health Maintenance: Normal:**

Mammogram in the previous 24 months: □ YES □ NO □ YES □ NO

Bone density in the previous 24 months: □ YES □ NO □ YES □ NO

Medical/Gyn exam in previous 24 months: □ YES □ NO □ YES □ NO

Pap Smear in the previous 24 months: □ YES □ NO □ YES □ NO

Pelvic Ultrasound in the previous 24 months: □ YES □ NO □ YES □ NO

Performs Regular Self Breast Exams: □ YES □ NO □ YES □ NO

**OB/GYN History:**

Number of pregnancies \_\_\_\_\_\_\_

Number of live birth: \_\_\_\_\_\_\_

Number of miscarriages: \_\_\_\_\_\_\_

Sexual orientation: □ Heterosexual □ Homosexual □ Bisexual

Check all that apply:

□ Regular Periods □ Irregular Periods □ Abnormal Pap

□ Abnormal Uterine Shape □ Breast Cancer □ C-Section(s)

□ Cone Biopsy of cervix □ Colposcopy □ Cryogen Treatment

□ Fibroids □ Genital Herpes □ H/O Pelvic Infections

□ Hysterectomy □ Infertility □ Laser Treatment for cervix

□ Menopause □ Ovarian Cancer □ STD(s)

□ Uterine Ablation □ Uterine Cancer □ PCOS (polycystic ovarian syndrome)

What type of contraception are you currently using (check all that apply)?

□ NONE □ Condoms □ Depo Provera □ Diaphram

□ Foam □ Hysterectomy □ IUD □ Natural Family Planning

□ Norplant □ Oral Contraception □ Plan B □ Tubal Ligation

□ Vasectomy □ Withdrawal

**SYMPTOM CHECKLIST**

**Please circle the symptoms you are experiencing and the frequency or severity of the symptoms:**

**Estrogen Related Symptoms:**

Night Sweats: □<3 times/week □ 1-3 times per night □ >3 times/night

Sleeping problems: □ Never □ 1-3 awakenings/week □ Sleep disturbance every night

Hot flashes/warm flushing: □ Never □ 1-3 flashes/night □ Frequently-Daily/Nightly

Pain with intercourse: □ Never □ Once in a while □ More often □ Always

Vaginal dryness: □ Never □ Once in a while □ Worsening □ Always

Urine leakage: □ Never □ When I cough, sneeze, or exercise □ Daily

**Testosterone Related Symptoms:**

Sexual Desire/Libido: □ Not a problem □ Less Desire □ No Desire

Difficulty Concentrating: □ Not a problem □ Worsening

Memory Loss: □ Not a problem □ Worsening or more forgetful

Foggy Thinking: □ Not a problem □ Worsening

Muscle Pain □ Never □ Occasionally □ More Often □ Daily

Joint Pain □ Never □ Occasionally □ More Often □ Daily

**Estrogen and Testosterone Related Symptoms:**

Mood Swings: □ No □ Before my Periods □ Getting worse & not sure why

Migraines/Headaches: □ Never □ 1-2 times/month □ More frequent/getting worse □ Daily

Depression: □ No □ Sad more than usual □ Affecting my job/relationships

Anxiety: □ No □ Worsening □ Affecting my job/relationships

**Please initial then sign below:**

**I authorize the above information is up to date and correct to the best of my knowledge.**

**Initial \_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

***Thank you for completing the Health History Form.***