



FEMALE PATIENT INFORMATION

Name: _____ Today's Date: MM/DD/YYYY
 LAST FIRST MIDDLE

Date of Birth: MM/DD/YYYY

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____

Do you have an email address you can share with us: _____

We would like to stay in contact with you at all times. If you have a second residence, please provide us with that information

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Business Telephone: _____

Marital status (please circle): Married Divorced Single Widow Living with Significant Other

In the event we are unable to contact you by the means you've provided above, we would like to have the ability to contact you through your spouse. Please provide the necessary information about your spouse below.

Spouse's Name: _____
 LAST FIRST MIDDLE

Spouse's Date of Birth MM/DD/YYYY

Spouse's Employer: _____

Business Telephone: _____

In case of an emergency, whom should we notify? Contact Name: _____

Contact Information: _____
 HOME TELEPHONE CELL PHONE E-MAIL

Relationship: _____

Signature: _____ Date: MM/DD/YYYY



What is the reason for your visit today? Please describe the symptoms & be specific:

How did you hear about us?:

SYMPTON CHECKLIST

Please indicate how often you have the following

- | | | | |
|---------------------------------------|-------------------------------------|---------------------------------|--------------------------------|
| Night sweats: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Hot flashes/hot flushes: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Pain with intercourse: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Vaginal dryness: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Sleeping problems: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Urine leaks when you cough or sneeze: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Difficulty concentrating/memory loss: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Mood swings: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Migraines: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Depression: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Anxiety: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Decrease in sexual desire: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Decrease in energy level: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Loss of memory: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Foggy thinking: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |
| Muscle and/or joint pain: | <input type="checkbox"/> Frequently | <input type="checkbox"/> Rarely | <input type="checkbox"/> Never |

Please check the boxes below if they apply to how you have dealt with the above symptoms

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| Herbal medications/supplements | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Please specify how: _____ | | |
| Change of diet: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Please specify how: _____ | | |
| Layered clothing: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Please specify how: _____ | | |
| Increase exercise: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Please specify how: _____ | | |
| Other: _____ | | |
| _____ | | |
| _____ | | |

GYN HISTORY

Are you sexually active: YES NO

Have you been sexually active: YES NO

Do you have pain with intercourse: YES NO

What type of contraception are you currently using (Please check below all that apply):

- Pills IUD Foam Condoms
 Tubal Ligation Vasectomy Diaphragm Withdrawal
 Implants Depo Provera
 Other: _____

What type of contraception have you used in the past (Please check below all that apply):

- Pills IUD Foam Condoms
 Tubal Ligation Vasectomy Diaphragm Withdrawal
 Implants Depo Provera
 Other: _____

Are you having any problems with your method of birth control: YES NO

Have you even had any vaginal, cervical and/or tubal infection: YES NO

If yes, please check below call that apply::

- Gardnerella Syphilis Condyloma Bacterial Vaginitis
 Yeast PID Herpes Chlamydia Gonorrhea Warts
 Other: _____

Date of last pap smear: _____

Have you ever had an abnormal pap smear YES NO

If yes, how was it treated (please check below all that apply):

- Repeated Pap Smear Colposcopy Laser Surgery Cone Biopsy
 Cryosurgery (freezing) Hysterectomy Loop Excition

Have you ever had cervical cancer: YES NO

If yes, how was it treated: _____

Have you ever had uterine cancer: YES NO

If yes, how was it treated: _____

Have you ever had ovarian cancer: YES NO

If yes, how was it treated: _____

Do you have trouble leaking urine: YES NO

Do you have any breast lumps, tenderness or discharge: YES NO

Have you ever had a mammogram: YES NO

If yes, was it normal: YES NO

Date of last mammogram: _____

Do you do self breast exams: YES NO

Do you have PMS symptoms: YES NO

If yes, are you currently undergoing treatment: YES NO

If yes, what type of treatment: _____

Do you have any uterine abnormality: YES NO

Do you have a history of infertility: YES NO

Do you have a history of DES exposure: YES NO

Do you have fibroids of the uterus: YES NO

Have you had abnormal bleeding in the past year: YES NO

If yes, please describe: _____

At what age did you start menopause: _____

MENSTRUAL HISTORY

If you no longer have periods, please check reason

Natural Hysterectomy Ablation Menopause

Do you have a uterus: YES NO

First day of last period: _____

Typically, how many days do your periods last: _____

Are your periods regular: YES NO

How many days are between the start of your periods: _____

Has the flow of your period changed in any way: YES NO

If yes, please explain the change: _____

Does bleeding occur between your normal period cycle: YES NO

Do you suffer from cramps during your periods: YES NO

If yes, please check the pain associated with the cramps:

MILD MODERATE SEVERE

What medicine, if any, are you currently taking for your cramps: _____

SOCIAL HISTORY

Do you smoke cigarettes: YES NO

If yes, please try list the number you smoke per day on average: _____

Please list the number of years you have been smoking: _____

- Do you use recreational drugs: YES NO
- Do you drink alcohol: YES NO
- If yes, what type of alcohol do you drink:
- How many drinks **per week**, on average, do you drink:
- Are you using any form of Testosterone or Hormone Therapy: YES NO
- If yes, please check which type:
- Gel Cream Shots Pellets Other

MEDICAL HISTORY

- Do you have **diabetes**: YES NO
- Do you have or have you ever had **hypertension**: YES NO
- Do you have **heart disease**: YES NO
- Have you ever had a **heart attack**: YES NO
- Have you ever had a **stroke**: YES NO
- Do you have a **heart murmur**: YES NO
- Do you have or have you ever had **kidney disease**: YES NO
- Have you ever been treated for a **psychiatric disorder**: YES NO
- If yes, please name the disorder: _____
- Have you ever had **rheumatic fever**: YES NO
- Do you have **mitral valve prolapse**: YES NO
- Have you ever had a **urinary tract infection**: YES NO
- Have you ever had **hepatitis**: YES NO
- If yes, please check which type:
- Hepatitis A Hepatitis B Hepatitis C Other
- Have you ever had **liver disease**: YES NO
- Have you ever had **varicose veins**: YES NO
- Have you ever had **phlebitis**: YES NO
- Do you have any **thyroid problems**: YES NO
- If yes, please check the problem**
- Low Function Overactive Goiter Hashimoto's
- Have you ever had a **blood transfusion**: YES NO
- Do you have **asthma, emphysema** or **chronic bronchitis**: YES NO

Do you have or have you ever had leukemia :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had lymphoma :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had colon cancer :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had colon polyps :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or have you ever had multiple myeloma :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or have you ever had lung cancer :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have or have you ever had rectal cancer :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Please check the type of treatment:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiation
Do you have or have you ever had breast cancer :	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, are you currently undergoing any treatment:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Please check the type of treatment

Lumpectomy
 Mastectomy
 Radiation Therapy
 Chemotherapy

Do you have any **drug allergies**: YES NO

If yes, please list the drugs you are allergic to:

Please list **all** major surgeries (including year and reason):

Please list any other operations/hospitalizations (including year and reason):

Have you ever had any anesthesia complications: YES NO

If yes, please explain:

Are you currently or have you ever been **anemic**: YES NO

Do you have an Internist or Family Physician: YES NO

Please list the name of the physician and a number where they may be reached:

Physician Name: _____ Physician Phone Number: _____

Are you currently taking any medications: YES NO

Please list the medications your are currently taking and the dosage amount:

Have you ever had your cholesterol checked: YES NO

If yes, what was the date it was last checked: _____

How was your cholesterol: Low Normal High

Do you have **arthritis**: YES NO

If yes, what type: _____

Do you have **lupus**: YES NO

Do you have **scleroderma**: YES NO

Do you have **rheumatoid arthritis**: YES NO

Have you had **blood clots in your legs or lungs**: YES NO

Do you have problems with **water retention**: YES NO

Do you have problems with **swelling**: YES NO

Do you have problems with **bloating**: YES NO

Do you have **osteopenia**: YES NO

If yes, how was it treated: _____

Do you have **osteoporosis**: YES NO

If yes, how was it treated: _____

Do you suffer from **hair loss**: YES NO

Do you suffer from or have you had **acne**: YES NO

FAMILY HISTORY

Do you have a family history of **breast cancer**: YES NO
If yes, with who in your family history: _____

Do you have a family history of **colon cancer**: YES NO
If yes, with who in your family history: _____

Do you have a family history of **ovarian cancer**: YES NO
If yes, with who in your family history: _____

Do you have a family history of **osteoporosis**: YES NO
If yes, with who in your family history: _____

Do you have a family history of **diabetes**: YES NO
If yes, with who in your family history: _____

Do you have a family history of **hypertension**: YES NO
If yes, with who in your family history: _____

Do you have a family history of **heart disease**: YES NO
If yes, with who in your family history: _____

Do you have a family history of **kidney disease**: YES NO
If yes, with who in your family history: _____

At what age did your mother go through menopause: _____