FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date:_____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Work: _____

May we send messages via text regarding appointments to your cell? Yes ▢ No ▢

Email address: _____

In case of emergency contact: _____ Relationship: _____

Home phone: _____ Cell: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address: _____

Marital status (check one): ▢ Married ▢ Divorced ▢ Widow ▢ Single ▢ Living with partner

In the event we cannot contact you by the means you have 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.

Name: _____ Relationship: _____ Phone: _____

SOCIAL HISTORY

▢ Still having a menstrual cycle, date of last menstrual cycle _____

▢ I am sexually active OR ▢ I want to be sexually active

▢ I have completed my family OR ▢ I have NOT completed my family

▢ My sex life has suffered OR ▢ I have not been able to have an orgasm, or it is difficult

▢ I do not want to be sexually active ▢ I am currently pregnant or trying to conceive

HABITS

▢ I smoke cigarettes/cigars _____ per day ▢ I use e-cigarettes _____ a day. ▢ I use caffeine _____ per day

▢ I drink alcoholic beverages _____ per week ▢ I drink more than 10 alcoholic beverages a week

DRUG ALLERGIES

Drug allergies ▢ Yes ▢ No If yes, explain _____

Have you ever had issues with local anesthesia? ▢ Yes ▢ No Do you have a latex allergy? ▢ Yes ▢ No

CURRENT MEDICATIONS

_____

_____

_____

Are you currently taking thyroid medication? ▢ Yes ▢ No If yes, what type? _____

Are you currently taking statins for cholesterol? ▢ Yes ▢ No

Are you currently taking birth control? ▢ Yes ▢ No If yes, what type? _____

Current hormone replacement therapy? ▢ Yes ▢ No If yes, what? _____

Past hormone replacement therapy? _____

Last physical? _____ Last mammogram? _____ Last pap? _____

FAMILY HISTORY

▢ Heart disease ▢ Diabetes ▢ Osteoporosis ▢ Alzheimer's/dementia ▢ Breast cancer

▢ Other _____

PERTINENT MEDICAL/SURGICAL HISTORY

▢ Breast cancer ▢ Seizures ▢ Endometriosis or history of endometriosis

▢ Fibrocystic breasts ▢ PCOS ▢ Uterine fibroids

▢ Hashimoto's thyroiditis ▢ Acne ▢ Breast tenderness

▢ Facial hair ▢ Hot flashes ▢ Premenstrual migraines

▢Uterine cancer ▢ Ovarian cancer ▢ Infertility

▢ Irregular or heavy periods ▢ Partial hysterectomy ▢ Total hysterectomy

BIRTH CONTROL

▢ Menopause ▢ Hysterectomy ▢ Tubal ligation

▢ Birth control pills ▢ Vasectomy ▢ IUD

▢ Infertility ▢ Other _____

MEDICAL HISTORY

▢ High blood pressure/hypertension ▢ Stroke and/or heart attack

▢ Heart disease ▢ HIV or hepatitis

▢ Atrial fibrillation or other arrhythmia ▢ Hemochromatosis

▢ Blood clot and/or pulmonary embolism ▢ Psychiatric disorder

▢ Depression/anxiety ▢ Thyroid disease

▢ Chronic liver disease (fatty liver, cirrhosis) ▢ Diabetes

▢ Arthritis ▢ Lupus or other autoimmune disease

▢ Sleep apnea ▢ High cholesterol

▢ Other _____