

What is your primary health concern or reason for considering bioidentical hormone replacement therapy? _____

OB / GYN HISTORY

- 1. Are you sexually active? YES NO
- 2. Have you been sexually active? YES NO
- 3. Do you have pain with intercourse? YES NO
- 4. Are you now or have you in the past used contraception? YES NO
If yes, what form: _____
- 5. Date of last pap smear: _____
- 6. Have you ever had abnormal pap smear? YES NO
If yes, how was it treated? Please check below:
 Repeated Pap Smear Colposcopy Laser Surgery Cone Biopsy
 Cryosurgery (freezing) Hysterectomy Loop Incision
- 7. Do you have problems leaking urine? YES NO
- 8. Do you have any breast lumps, tenderness or discharge? YES NO
- 9. Have you had a mammogram? YES NO
If yes, was it normal? YES NO
Date of last mammogram: _____
- 10. Do you have any PMS symptoms? YES NO
If yes, any treatment? _____
- 11. Do you have any hot flashes or menopausal symptoms? YES NO
- 12. Do you have any uterine anomalies? YES NO
- 13. If you no longer have periods, please state reason: _____
- 14. Are you periods regular? YES NO
- 15. Do you have any bleeding between periods? YES NO
- 16. Do you have any cramping with your periods? YES NO
If yes, circle one: mild moderate severe
- 17. Medicine taken for cramps? _____
- 18. Do you have:
Fatigue? YES NO
Decrease of memory? YES NO

Decrease of energy level?

YES NO

Decrease of sexual drive?

YES NO

19. Do you suffer from:

Anxiety?

YES NO

Irritability?

YES NO

Mood swings?

YES NO

Migraines?

YES NO

20. How have you dealt with these symptoms?

21. Is your sex drive the same as it was five years ago?

YES NO

Describe: _____

22. List any other sexual dysfunctions:

23. Have you experienced weight gain in the last one-two years?

YES NO

If yes, please describe: _____

24. Have you lost greater than 10 pounds in less than a month?

YES NO

If yes, why? _____

25. List current medications:

PAST MEDICAL HISTORY

- 1. Do you have diabetes? YES NO
- 2. Do you have/had hypertension? YES NO
- 3. Do you have heart disease? YES NO
- 4. Do you have a heart murmur? YES NO
- 5. Do you have/had kidney disease? YES NO
- 6. Have you ever been treated for psychiatric problems? YES NO
- 7. Have you ever had rheumatic fever? YES NO
- 8. Do you have mitral valve prolapse? YES NO
- 9. Have you ever had a urinary tract infection? YES NO
- 10. Have you ever had hepatitis/liver disease? YES NO
- 11. Have you ever had varicosities/phlebitis? YES NO
- 12. Do you have any thyroid problems? YES NO
- 13. Have you had any major accidents? YES NO
- 14. Have you ever had any blood transfusions? YES NO
- 15. Do you have asthma/lung disease? YES NO
- 16. Do you have lupus, Scleroderma or similar diseases? YES NO

If yes, please describe: _____

- 17. Do you have arthritis? YES NO

If yes, what type: _____

- 18. Do you have any Drug Allergies? YES NO

If yes, please list: _____

- 19. List any surgeries:

- 20. List any other operations/hospitalizations (include year & reason):

- 21. Have you had any anesthesia complications? YES NO

If yes, please list: _____

22. Have you ever been anemic? YES NO
23. Do you have an Internist or Family Doctor? YES NO
 If yes, please list name, phone number: _____
24. Have you had your cholesterol checked? YES NO
 If yes, date last checked _____
 Was it normal? YES NO

SOCIAL HISTORY

1. Do you smoke cigarettes? YES NO
 If yes, number per day? _____ Number of years? _____
2. Do you drink alcohol? YES NO
 If yes, how much per day? _____

FAMILY HISTORY

1. Do you have a family history of breast cancer? YES NO
 If yes, whom? _____
2. Do you have a family history of colon cancer? YES NO
 If yes, whom? _____
3. Do you have a family history of ovarian cancer? YES NO
 If yes, whom? _____
4. Do you have a family history of osteoporosis? YES NO
 If yes, whom? _____
5. Do you have a family history of diabetes? YES NO
 If yes, whom? _____
6. Do you have a family history of hypertension? YES NO
 If yes, whom? _____
7. Do you have a family history of heart disease? YES NO
 If yes, whom? _____
8. Do you have a family history of kidney disease? YES NO
 If yes, whom? _____



Hormone Imbalance Checklist

Name: _____ Date: _____

New Patients: Please indicate current symptoms with an X.

Follow-up Patients: Please indicate changes in your symptoms since your initial visit. Use a scale of 0 - 10, with 10 meaning there has been no change in symptoms and 0 meaning symptom has completely been relieved.

- | | | |
|--------------------------------|----------------------------------|---------------------------------|
| _____ Burned-out feeling | _____ Weight gain in waist | _____ Decreased libido |
| _____ Foggy thinking | _____ Inability to lose weight | _____ Erectile dysfunction |
| _____ Anxiety | _____ Hot flashes | _____ Prostate problems |
| _____ Stress | _____ Night sweats | _____ Increased urinary urge |
| _____ Lack of motivation | _____ Sleep disturbances | _____ Infertility problems |
| _____ Apathy | _____ Oily skin | _____ Decreased urine flow |
| _____ Depression | _____ Decreased stamina | _____ Decreased erections |
| _____ Irritability | _____ Aches and pains | _____ Blood sugar imbalance |
| _____ Morning fatigue | _____ Elevated triglycerides | _____ Cold body temperature |
| _____ Evening fatigue | _____ Decreased muscle mass | _____ Constipation |
| _____ General fatigue | _____ Bone loss | _____ Headaches |
| _____ Chronic illness | _____ Elevated cholesterol | _____ Allergies |
| _____ Fibromyalgia | _____ Decreased mental sharpness | _____ Susceptible to infections |
| _____ Autoimmune illness | _____ Vaginal Dryness | |
| _____ Other: please list _____ | | |



MAMMOGRAM/ PAP SMEAR WAIVER
FOR ESTRADIOL & TESTOSTERONE PELLETT
THERAPY

I, _____, voluntarily choose to undergo implantation of sub-dermal bio identical Estradiol & Testosterone pellet therapy. For today's appointment, I have not provided you with: _____ mammogram and/or _____ pap smear due to:

- _____ My decision not to have one or both
OR
- _____ I am unable to provide at my consultation appointment.

I have voluntarily chosen to sign this release form. I agree that if any breast or uterine issues arise and/or develop while on pellet therapy, I release _____ from any liability.

Signed: _____

Date: _____