FEMALE PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

How did you hear about us? □ Patient (Name: _____) □ Event (_____)
□ Practitioner (Name: _____) □ Pharmacy (Name: _____)
□ Social Media (Type: _____) □ TV (Station: _____) □ Radio (Station: _____)
□ Web (Keyword Searched: _____) □ Signage (_____) □ Print (Ad seen in: _____)

In Case of Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work: _____

Pharmacy Name: _____ Phone: _____

Address: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

OBGYN Physician's Name: _____ Phone: _____

Address: _____

May we share your clinical information with your PCP/Gyn? □ Yes □ No

MEDICAL HISTORY

Weight: _____ Last Menstrual Period: _____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

Do you smoke? ( ) Yes ( ) No ( ) Quit How much? _____ How often? _____ Age started? _____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much? _____ How often? _____ Age started? _____

Any known drug allergies: ( ) Yes ( ) No If yes please explain: _____

Current Medications and dosage: _____

_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy: _____ Past HRT: _____

Surgeries, list all and when: _____

Other Pertinent Information: _____

Do you have a family history of? ( ) Heart Disease ( ) Cancer ( ) Diabetes ( ) Other _____

Do you have a personal history of? Check all that apply.

Preventative Medical Care:
( ) Medical/GYN Exam in the last year.
( ) Mammogram in the last 12 months.
( ) Bone Density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:
( ) Breast Cancer.
( ) Uterine Cancer.
( ) Ovarian Cancedr
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy Removal of Ovaries.

Birth Control Method:
( ) Menopause.
( ) Hysterectomy.
( ) Tubal Ligation.
( ) Birth Control Pills.
( ) Vasectomy.
( ) Other: _____

Medical Illnesses:
( ) High blood pressure.
( ) Heart bypass.
( ) High cholesterol.
( ) Hypertension.
( ) Heart Disease.
( ) Stroke and/or heart attack.
( ) Blood clot and/or a pulmonary emboli.
( ) Arrhythmia.
( ) Any form of Hepatitis or HIV.
( ) Lupus or other auto immune disease.
( ) Fibromyalgia.
( ) Trouble passing urine or take Flomax or Avodart.
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis).
( ) Diabetes.
( ) Thyroid disease.
( ) Arthritis.
( ) Depression/anxiety.
( ) Psychiatric Disorder.
( ) Cancer Type: _____ Year: _____

PRINT NAME _____ **SIGNATURE** _____ **DATE** _____

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

☐For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. **Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. **Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

_____

_____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ➔ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?

_____

_____

FOR OFFICE USE ONLY

CHART ID:_____ **DOB:**_____ **APPT DATE:**_____