



Personal Data		
Name	Date	Social Security #
Address	City State	Zip
Home phone	Work phone/Cell phone	Date of birth
Occupation/Employer	Emergency Contact	Phone
Email	Marital Status Married Single	
Primary Care Physician		
Name	Phone/Fax Number	
Address	City State	Zip
Pharmacy Name	Phone/Fax Number	

Present Symptoms
Please briefly describe your symptoms.
What do you feel is the most important factor to your present symptoms?

Allergies

Are you allergic to any MEDICATIONS (Prescription, OTC and Supplements)

Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), etc. If a member is deceased, please list age of death and cause if known.

Relationship	Age	Medical Problem(s)/ Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History

Please remember that this information is strictly confidential and will be used **only** to address your symptoms and/or complaints

Do you smoke cigarettes now or have you in the past? Yes No

- If yes, how many packs per day? _____
- How many total years have you smoked? _____

Do you drink alcohol? Yes No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits etc.) do you have in an average week? _____

Do you now or have you in the past used any illicit drugs (marijuana, cocaine, amphetamines, opiates, narcotics, LSD (acid), etc.)? Yes No

- If yes, what substance(s) and how often? _____

Gynecological History

Date of last PAP smear? _____ Physician who performed? _____

Physician's Phone Number _____

Date of last mammogram? _____ Facility where performed: _____

Facility Phone Number: _____

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have _____		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes?		
Have you noticed any lumps in your breasts?		
Are you using a birth control method? If yes, what kind? _____		
Are you still having menstrual periods? If yes, when was the first day of Your last period? _____		

Please describe any problems you have with your periods:

Periods are (were): regular irregular painful crampy heavy light other

Age periods began: _____ # days of bleeding _____ cycle length (days) _____

If you are no longer having periods, at what age did your periods stop? _____

If your periods stopped less than one year ago, how many months ago was your last period? _____

Did your periods stop because you had a hysterectomy? Yes No

- If yes, what was the reason for the surgery? _____

- Were the ovaries removed at the same time? Yes No Not Sure

Do you have a history of any of the following cancers:

- | | | |
|---------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Vulva | <input type="checkbox"/> Ovary | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Uterus | <input type="checkbox"/> Fallopian Tube | |
| <input type="checkbox"/> Vagina | <input type="checkbox"/> Breast | _____ |
| <input type="checkbox"/> Cervix | <input type="checkbox"/> Colon | _____ |

Hormonal Imbalances History

Have you been treated with any hormone replacement therapy? If yes, please give approximate Periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Estrogens

Check which of these symptoms are troublesome and have persisted over time

Estrogen Deficiency	Estrogen Excess / Progesterone Deficiency	
<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Foggy Thinking <input type="checkbox"/> Memory Lapses <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Tearful <input type="checkbox"/> Depressed <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Heart Palpitations/Arrhythmia <input type="checkbox"/> Bone Loss <input type="checkbox"/> Headaches	<input type="checkbox"/> Mood Swings (PMS) <input type="checkbox"/> Cystic Ovaries <input type="checkbox"/> Tender Breasts <input type="checkbox"/> Heavy Menses <input type="checkbox"/> Water Retention <input type="checkbox"/> Sugar Craving <input type="checkbox"/> Nervousness <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Fibrocystic Breast <input type="checkbox"/> Headaches <input type="checkbox"/> Cold Body Temperature	<input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Weight Gain – Hip Area <input type="checkbox"/> Bleeding Changes <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Low Libido

Androgens

Check which of these symptoms are troublesome and have persisted over time

Androgen Excess	Androgen Deficiency	
<input type="checkbox"/> Increased Facial Hair <input type="checkbox"/> Increased Body Hair <input type="checkbox"/> Acne <input type="checkbox"/> Oily Skin <input type="checkbox"/> Nervous <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Ovarian Cysts <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Prostrate Problems	<input type="checkbox"/> Low Libido <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Fatigue <input type="checkbox"/> Aches/Pains <input type="checkbox"/> Memory Lapses <input type="checkbox"/> Foggy Thinking <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious <input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Apathy/Decreased Passion for Life <input type="checkbox"/> Decreased Muscle Mass	<input type="checkbox"/> Heart Palpitations/Arrhythmia <input type="checkbox"/> Headaches <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Irritable <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Bone Loss

Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess		Cortisol Deficiency
<input type="checkbox"/> Sleep Disturbances <input type="checkbox"/> Bone Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight Gain – Waist <input type="checkbox"/> Loss of Muscle Mass <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Breast Cancer <input type="checkbox"/> Irritable <input type="checkbox"/> Anxious <input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Heart Palpitation/Arrhythmia <input type="checkbox"/> Headaches <input type="checkbox"/> Stress <input type="checkbox"/> Nervousness <input type="checkbox"/> Sugar Cravings <input type="checkbox"/> Low Libido <input type="checkbox"/> Hair Loss <input type="checkbox"/> Increased Facial Hair <input type="checkbox"/> Increased Body Hair <input type="checkbox"/> Acne	<input type="checkbox"/> Exhaustion/Fatigue <input type="checkbox"/> Sugar Craving <input type="checkbox"/> Allergies <input type="checkbox"/> Chemical Sensitivity <input type="checkbox"/> Stress <input type="checkbox"/> Apathy/Decreased Passion for Life <input type="checkbox"/> Irritable <input type="checkbox"/> Arthritis <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Aches/Pains <input type="checkbox"/> Cold Body Temperature

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess	Thyroid Deficiency	
<input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Irritable <input type="checkbox"/> Heart Palpitations/Arrhythmia <input type="checkbox"/> Weight Loss <input type="checkbox"/> Tremors/Shakiness <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nervousness/Anxious/Panic Attacks <input type="checkbox"/> Insomnia <input type="checkbox"/> Difficulty Conceiving/Infertility	<input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Constipation <input type="checkbox"/> Fatigued/Weakness <input type="checkbox"/> Unexplained Weight Gain <input type="checkbox"/> Inability to Lose Weight <input type="checkbox"/> Stress <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Coarse Dry Skin <input type="checkbox"/> Lack of Motivation <input type="checkbox"/> Voice has become hoarse	<input type="checkbox"/> Aches/Pains <input type="checkbox"/> Hair Loss <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Cramps

System Review – Check the appropriate box for each question.

Constitutional / ID / Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a persistent cough?			
Do you have recurrent sinus infections?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema?			

System Review – Check the appropriate box for each question.

Cardiovascular	Yes	No	Not Sure
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Vascular disease or artery blockages/aneurysms?			
Have you been diagnosed with any heart condition? Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated blood sugar? Diabetes?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			