



Patient Name: \_\_\_\_\_

Patient Identifier: \_\_\_\_\_

### **Patient Information**

Please complete the following information in preparation for your consultation.

Date: \_\_\_\_\_

Street address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Phone: \_\_\_\_\_ (home/work)

Race: \_\_\_\_\_ Caucasian \_\_\_\_\_ African American

Cell: \_\_\_\_\_

\_\_\_\_\_ Asian \_\_\_\_\_ Native American

Email: \_\_\_\_\_

\_\_\_\_\_ Hispanic \_\_\_\_\_ Other \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ feet \_\_\_\_\_ inches

Doctor's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_ Reaction: \_\_\_\_\_

### **Social History**

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Partnered \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Exercise: \_\_\_\_\_ Minutes \_\_\_\_\_ Times per week

Caffeine: \_\_\_\_\_ Cups/day

Alcohol: \_\_\_\_\_ Drinks/week

Tobacco: \_\_\_\_\_ Packs/day for \_\_\_\_\_ years (\_\_\_\_\_ current or quit \_\_\_\_\_ years/months ago)

Illicit Drugs: \_\_\_\_\_

Occupation: \_\_\_\_\_

### **Social (continued):**

( ) I am sexually active.

( ) I want to be sexually active.

( ) I have completed my family.

( ) My sex has suffered.

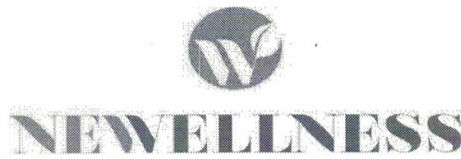
( ) I haven't been able to have an orgasm.

### **Family History**

Please indicate next to each condition whether family member is Grandparent, Father Mother, Sister, or Brother.

_____ Cancer	_____ Diabetes	_____ High Cholesterol	_____ High Blood Pressure
_____ Depression	_____ Heart Attack	_____ Kidney Disease	_____ Stroke
_____ Mental Illness	_____ Lung Disease	_____ Asthma	

Other: \_\_\_\_\_



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Past Surgical History

\_\_\_ Appendectomy \_\_\_ Angioplasty \_\_\_ CABG (Bypass) \_\_\_ Gall Bladder Removal  
\_\_\_ Knee \_\_\_ Hip \_\_\_ Pacemaker \_\_\_ Other: \_\_\_\_\_

**Hysterectomy:** ( ) YES ( ) NO

**Ovaries removed:** ( ) YES ( ) NO

\_\_\_ Number of children

Past Medical History

___ Cancer	___ Diabetes	___ High Cholesterol	___ High Blood Pressure
___ Depression	___ Heart Disease	___ Kidney Disease	___ Stroke
___ Mental Illness	___ Lung Disease	___ Asthma	___ Ulcers
___ Gout	___ Thyroid Dis.	___ Irregular Heart Beat	___ Rheumatoid Arthritis
___ Fibroids	___ TB	___ Low blood sugar	___ Painful Heel
___ Gallstones	___ GERD/Reflux	___ Other(s): _____	

\_\_\_ Heart Disease/or Heart attack  
\_\_\_ Blood Clot or Pulmonary embolism  
\_\_\_ Arrhythmia  
\_\_\_ Any form of Hepatitis  
\_\_\_ HIV  
\_\_\_ Lupus or other auto immune disease \_\_\_\_\_  
\_\_\_ Fibromyalgia  
\_\_\_ Fibrocystic breast disease  
\_\_\_ Osteoarthritis  
\_\_\_ Anxiety  
\_\_\_ Psychiatric Disorder.  
\_\_\_ Cancer (type): \_\_\_\_\_  
Year: \_\_\_\_\_

**Birth Control Method:**

( ) Menopause.  
( ) Tubal Ligation.  
( ) Birth Control Pills.  
( ) Other: \_\_\_\_\_ Hysterectomy (year) \_\_\_\_\_

\_\_\_ Irregular cycles \_\_\_ Heavy menstruation  
\_\_\_ Date of last period \_\_\_ Amount of days \_\_\_ Normal, Heavy or Light? \_\_\_\_\_

Other menstrual Disorder: \_\_\_\_\_



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- ( ) Medical/GYN Exam in the last year.
- ( ) Bone Density in the last 12 months.
- ( ) Pelvic ultrasound in the last 12 months.

**Last Pap (date):** \_\_\_\_\_ **Normal:** ( ) YES ( ) NO

\_\_\_\_\_ Flu      \_\_\_\_\_ Pneumonia      \_\_\_\_\_ Shingles      \_\_\_\_\_ Tetanus      \_\_\_\_\_ Other: \_\_\_\_\_

Please include all prescribed, over-the-counter, supplements, herbals, and/or botanicals

[illegible]



## NEWWELLNESS

### BHRT CHECKLIST FOR WOMEN

Name: \_\_\_\_\_ Date: \_\_\_\_\_

#### Symptoms (please check mark)

	Never	Mild	Moderate	Severe
Depressive mood				
Sleep problems				
Mood changes/Irritability				
Migraine/Severe headaches				
Swelling all over the body				
Tension				
Bloating				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Hair loss				
Fatigue (Tiredness)				
Memory loss				
Mental confusion				
Decreased sex drive/Libido				
Difficult to climax sexually				
Weight gain				
Joint pain				

**Any changes in your personal history:** Yes No

**If yes, please explain:** \_\_\_\_\_

**Any changes in medications:** Yes No

**If yes, please explain:** \_\_\_\_\_

**Last Menstrual Period** \_\_\_\_\_

**Other symptoms that concern you:** \_\_\_\_\_

#### Personal/Family History

Heart Disease  
Diabetes  
Osteoporosis  
Alzheimer's Disease  
Breast Cancer

NO

YES
