FEMALE PATIENT INFORMATION

BIO-IDENTICAL HORMONE REPLACEMENT THERAPY (BHRT)

Date:_____

Name: _____
Last First Middle

Date of birth:_____(MM/DD/YYYY) SS#:_____-_____-_____

Street Address:_____

City, State, Zip:_____

Reliable Phone Number:_____

E-mail:_____

Employer:_____

Employer Street Address:_____

Employer City, State, Zip:_____

Business Phone Number:_____

Marital Status (circle): Married Divorced Single Widow Living with Partner

Spouse/Partner Name:_____

Spouse/Partner Phone Number:_____

In Case of Emergency Please Contact:_____

Relationship:_____Contact Phone Number:_____

Signature:_____Date:_____

Louisville Lifestyle Medicine

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Please describe you symptoms and reason for appointment:

_____
_____
_____
_____
_____
_____
_____
_____

What are you hoping to improve in your lifestyle:

_____
_____
_____
_____
_____

How did you hear about us?_____
_____
_____

SYMPTOMS

Please indicate how often you have the following:

Night sweats:	Frequently □	Rarely □	Never □
Hot flashes/hot flushes:	Frequently □	Rarely □	Never □
Pain with intercourse:	Frequently □	Rarely □	Never □
Vaginal dryness:	Frequently □	Rarely □	Never □
Sleeping problems:	Frequently □	Rarely □	Never □
Urine leaks when you cough or sneeze:	Frequently □	Rarely □	Never □

Difficulty concentrating/ memory loss:	Frequently □	Rarely □	Never □
Mood swings:	Frequently □	Rarely □	Never □
Migraines:	Frequently □	Rarely □	Never □
Depression:	Frequently □	Rarely □	Never □
Anxiety:	Frequently □	Rarely □	Never □
Decrease in sexual desire:	Frequently □	Rarely □	Never □
Decrease in energy level:	Frequently □	Rarely □	Never □
Loss of memory:	Frequently □	Rarely □	Never □
Foggy thinking:	Frequently □	Rarely □	Never □
Muscle and/or joint pain:	Frequently □	Rarely □	Never □

Pease check the boxes below if they apply to how you have dealt with the above symptoms

Herbal medications/supplements YES □ NO □

Please specify how:_____

Change of diet: YES □ NO □

Please specify how:_____

Layered clothing: YES □ NO □

Please specify how:_____

Increase exercise: YES □ NO □

Please specify how:_____

Other treatments done to help elevate symptoms:

_____
_____
_____
_____

_

GYNOCOLOGICAL HISTORY

Are you sexually active? YES NO

Have you been sexually active? YES NO

Do you have pain with intercourse? YES NO

What type of contraception are you currently using (Please circle all that apply)?

Pills IUD Foam Condoms

Tubal Ligation Vasectomy Diaphragm Withdrawal

Implants Depo Provera

Other:_____

What type of contraception have you used in the past (Please circle all that apply)?

Pills IUD Foam Condoms

Tubal Ligation Vasectomy Diaphragm Withdrawal

Implants Depo Provera

Other:_____

Are you having any problems with your method of birth control? YES NO

Have you ever had any vaginal, cervical and/or tubal infection? YES NO

If yes, please circle all that apply:

Gardnerella Syphilis Condyloma Bacterial Vaginitis

Yeast PID Herpes Chlamydia Gonorrhea Warts

Other:_____

Date of last pap smear:_____

Have you ever had an abnormal pap smear? YES NO

If yes, how was it treated (please circle all that apply)?

Repeated Pap Smear Colposcopy Laser Surgery Cone Biopsy

Cryosurgery (freezing) Hysterectomy Loop Excition

Have you ever had cervical cancer? YES NO

If yes, how was it treated? _____

Have you ever had uterine cancer? YES NO

If yes, how was it treated? _____

Have you ever had ovarian cancer? YES NO

If yes, how was it treated? _____

Do you have problems with leaking urine? YES NO

Do you have any breast lumps, tenderness or discharge? YES NO

Have you ever had a mammogram? YES NO

If yes, was it normal? YES NO

Date of last mammogram:_____

Do you do monthly self-breast exams? YES NO

Do you have PMS symptoms? YES NO

If yes, are you currently undergoing treatment? YES NO

If yes, what type of treatment?_____

Do you have any uterine abnormality? YES NO

Do you have a history of infertility? YES NO

Do you have a history of DES exposure? YES NO

Do you have fibroids of the uterus? YES NO

Have you had abnormal bleeding in the past year? YES NO

If yes, please describe:_____

At what age did you start menopause?_____years old

MENTRUAL HISTORY

If you no longer have periods, please circle reason:

Natural Hysterectomy Ablation Menopause

Do you have a uterus? YES NO

First day of last period:_____

Typically, how many days do your periods last?_____days

Are your periods regular? YES NO

How many days are between the start of your periods?_____days

Has the flow of your period changed in any way? YES NO

If yes, please explain:_____

Does bleeding occur between your normal period cycle? YES NO

Do you suffer from cramps during your periods? YES NO

If yes, please circle the pain level(s)associated with the cramps:

MILD MODERATE SEVERE

What medicine, if any, are you currently taking for your cramps?_____
_____

Any other information that is related to your menstrual cycle that is not included above?

_____
_____
_____
_____

SOCIAL/WELLNESS HISTORY

Do you smoke cigarettes? YES NO USED TO

If yes, please indicate the number of cigarettes you smoke(d) per day on average: _____

Please list the number of years you have/had been smoking:_____years

Do you use recreational drugs? YES NO

Do you drink alcohol? YES NO

If yes, what type of alcohol do you drink?_____

How many drinks per week, on average, do you drink?_____

Are you using any form of Testosterone or Hormone Therapy? YES NO

If yes, please circle which type:

Gel Cream Shots Pellets Other

How many hours of sleep do you get a night?_____hours

How often does your sleep during the night get interrupted:

Never Rarely Often Can't Keep Count

MEDICAL HISTORY

Do you have diabetes? YES NO

Do you have or have you ever had hypertension? YES NO

Do you have heart disease? YES NO

Have you ever had a heart attack? YES NO

Have you ever had a stroke? YES NO

Do you have a heart murmur? YES NO

Do you have or have you ever had kidney disease? YES NO

Have you ever been treated for a psychiatric disorder? YES NO

If yes, please name the disorder:_____

Have you ever had rheumatic fever? YES NO

Do you have mitral valve prolapse? YES NO

Have you ever had a urinary tract infection? YES NO

Have you ever had hepatitis? YES NO

If yes, please circle which type:

Hepatitis A Hepatitis B Hepatitis C Other

Have you ever had liver disease? YES NO

Have you ever had varicose veins? YES NO

Have you ever had phlebitis? YES NO

Do you have any thyroid problems? YES NO

If yes, please circle the symptoms:

Low Function Overactive Goiter Hashimoto's

Have you ever had a blood transfusion? YES NO

Do you have asthma, emphysema or chronic bronchitis? YES NO

Do you have or have you ever had leukemia? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment: Surgery Radiation

Do you have or have you ever had lymphoma? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment? Surgery Radiation

Do you have or have you ever had colon cancer? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment: Surgery Radiation

Do you have or have you ever had colon polyps? YES NO

If yes, are you currently undergoing any treatment? YES NO

Do you have or have you ever had multiple myeloma? YES NO

If yes, are you currently undergoing any treatment? YES NO

Do you have or have you ever had lung cancer? YES NO

If yes, are you currently undergoing any treatment? YES NO

Do you have or have you ever had rectal cancer? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment: Surgery Radiation

Do you have or have you ever had breast cancer? YES NO

If yes, are you currently undergoing any treatment? YES NO

Please circle the type of treatment:

Lumpectomy Mastectomy Radiation Therapy Chemotherapy

Do you have any drug allergies? YES NO

Are you HIV positive? YES NO

Sexual Orientation: Heterosexual Homosexual Bisexual

If yes, please list the drugs you are allergic to:_____
_____
_____

Please list all major surgeries/hospitalizations (including year and reason):
_____
_____
_____
_____
_____

Have you ever had any anesthesia complications? YES NO
If yes, please explain:_____
_____
_____

Are you currently or have you ever been anemic? YES NO

Do you have a Family Physician? YES NO

Please list the name of the physician and a number where they may be reached:

Physician Name:_____

Phone Number:_____

Are you currently taking any medications? YES NO

Please list the medications and dosage you are currently taking:

_____

_____

_____

Have you ever had your cholesterol checked? YES NO

If yes, what was the date it was last checked:_____

How was your cholesterol? Low Normal High

Do you have arthritis? YES NO

If yes, what type:_____

Do you have lupus? YES NO

Do you have scleroderma? YES NO

Do you have rheumatoid arthritis? YES NO

Have you had blood clots in your legs or lungs? YES NO

Do you have problems with water retention/swelling/bloating? YES NO

Do you have osteopenia? YES NO

If yes, how was it treated:_____

_____

Do you have osteoporosis? YES NO

If yes, how was it treated:_____

_____

Do you suffer from hair loss? YES NO

Do you suffer from acne or have you? YES NO

FAMILY HISTORY

Do you have a family history of breast cancer? YES NO

If yes, what family member(s)?_____

Do you have a family history of colon cancer? YES NO

If yes, what family member(s)?_____

Do you have a family history of ovarian cancer? YES NO

If yes, what family member(s)?_____

Do you have a family history of osteoporosis? YES NO

If yes, what family member(s)?_____

Do you have a family history of diabetes? YES NO

If yes, what family member(s)?_____

Do you have a family history of hypertension? YES NO

If yes, what family member(s)?_____

Do you have a family history of heart disease? YES NO

If yes, what family members?_____

Do you have a family history of kidney disease? YES NO

If yes, what family member(s)?_____

At what age did your mother start menopause?_____

At what age did your mother end menopause?_____

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