Optimal Vitality Female Intake Form

Name	Date of Birth	Age
Street Address	City, State, Zip Code	Best Phone to Reach You
Cell Phone	Can We Leave A Message/text? (yes or no)	Email
Employer	Occupation	Spouse / Partner
Emergency Contact/Phone	Primary Care Physician	Referred By

Medical and Family History	Self	Family		Self	Family		Self	Family
Seizures			Asthma/COPD			Diarrhea		
Migraines or Headaches			Sleep Apnea			Liver Disease		
Dizziness			Pulmonary Hypertension			Gallbladder Disease/ Stones		
Loss of Consciousness			Shortness of Breath			Ulcers		
Stroke			Irregular Heart Rhythm			Colitis		
Glaucoma			Heart Attack or Angina			Constipation		
Thyroid Disorder			Palpitations			Arthritis		
Obesity/Overweight			Heart Valve Disorder			Gout		
Diabetes Mellitus (DM)			Heart Failure			Osteopenia or Osteoporosis		
High Blood Sugar			High Blood Pressure			Kidney Disease or Stones		
Abnormal Cholesterol			Rheumatic Fever			Alcohol Abuse		
Insomnia			Tuberculosis			Drug Abuse		
Dementia			HIV			Eating Disorder		
Other:			Cancer Type:			Other Psychiatric Illness		

ALLERGIES List all allergies to medications and reactions.

Medication	Reaction

Latex Allergy ( ) No ( ) Yes

CURRENT MEDICATIONS

Name of Medication	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

CURRENT SUPPLEMENTS (Vitamins, Minerals, Herbs, etc.)

Name of Supplement	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

PREVIOUS SURGERIES

Surgery / Procedure	Date

MEDICAL CARE	DATE	RESULTS OR FINDINGS
Physical Exam		
Gynecological Exam		
Bone Density		
Colonoscopy		
Mammography		
Cardiac Test (EKG, Echo, Stress, etc.)		

DIET AND LIFESTYLE

List dietary restrictions or food allergies:

Describe typical meals:	
Breakfast	
Lunch	
Dinner	
Snacks	

HABITS	Yes	No	Amount / Type
Do you get regular exercise?			
Do you consume alcohol?			
Do you smoke?			
Experience excessive stress?			

GYNECOLOGICAL HISTORY

Age Started Menstruation: _____ Date of Last Menstrual Cycle: _____
Age Stopped if Post-Menopausal: _____
Have you had a hysterectomy? Yes: ____ No: _____ If so, when? _____
Reason: _____
Do you have ovaries: Yes:_____ No:_____ Are your periods regular? Yes: _____ No: ____
How many days do your cycles last? _____
Are your cycles heavy? Yes: ____ No: ____ Bleeding between periods? Yes: _____ No: ____
Endometriosis? Yes: _____ No: _____
Do you have menstrual cramps? Yes:_____ No_____ If so, are they mild? ____ severe? ____
Number of Pregnancies: _____ Number of Children: _____
Have you had a miscarriage Yes: _____ No: _____ If yes, how many? _____
Do you PMS symptoms? Yes: _____ No: _____ If yes, how many days do symptoms last? ___

HORMONE USAGE

Do you take hormones of any kind? Yes_____ No_____ If so, list (include birth control pills, HRT, or natural hormone (s):

Brand	Dose	How Often	Date Started

If you are currently taking hormones, what specific symptoms are improved? Please list:

_____

_____

If you are currently taking hormones, are you experiencing any unwanted side effects? Please list:

_____

Are you familiar with bioidentical hormones? Yes_____ No_____

Have you tried other hormones? Yes: No: If yes, list below:

Brand	Dose	How Often	Date Started	Reason Stopped

Other Information and Concerns	Yes	No
Are you interested in more information about weight loss?		
Are you interested in weight loss medication or programs?		
Are you interested in information about anti-aging skin care?		
Have you ever considered having Botox?		
Are you interested in physician recommended supplements for women's health?		
Are you interested in supplements for various other health concerns?		
Would you like information on men's health to take to your family members or friends?		
Are you interested in lab testing that identifies vitamin deficiencies?		
Would you be interested in inviting your physician to your company or business organization for a presentation on women's health?		
Would you like more information on our concierge program?		
Are there other health concerns that you want to discuss with your physician? Feel free to list here:		

Menopause Rating Scale (MRS)

Which of the following symptoms apply to you at this time?

(X ONE Box For EACH Symptom) For Symptoms That Do Not Apply, Please Mark "None").

Symptoms:	none	mild	moderate	severe	extremely severe
Score =	0	1	2	3	4
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)	☐	☐	☐	☐	☐