

NEW PATIENT QUESTIONNAIRE

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

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: _____ Other: _____

In Case of Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work: _____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? [] Electronic [] Paper

MEDICAL HISTORY

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

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 Year: _____

Other Pertinent Information: _____

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 Cancer
() Hysterectomy with removal of ovaries
() Hysterectomy only
() Oophorectomy Removal of Ovaries
() Prostate Cancer

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