

Female New Patient Questionnaire

Patient Demographics

First Name:	Middle:	Last Name:	
Home Phone:		Cell Phone:	
Email:			SSN:
Address:			City:
State:	Zip:	Age:	Date of Birth:
Referred by:		Primary Care Physician:	
OBGYN:		Marital Status:	
Occupation:		Employer:	

Medical Information

Last Menstrual Period:		Number of Pregnancies:	
Height:	Weight:	Number of Children:	
Blood Pressure: (Office use only)			

Emergency Contact Information

Name:	Relationship:
Primary Phone:	Secondary Phone:
Email:	

Reason for Visit:

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Allergies (List all allergies - Food, Drug, Other)

Current Medications (List all current medications)

Drug	Dose	How Often?

Supplements (List all current supplements)

Supplement	Dose	How Often?

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Symptoms of Hormonal Deficiencies (check all that apply)

<input type="checkbox"/>	Decreased or absent sex drive (libido)
<input type="checkbox"/>	Fatigue and lack of energy
<input type="checkbox"/>	Infrequent or absent orgasms
<input type="checkbox"/>	Change in mood, anxiety and/or depression
<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Declining mental ability and memory
<input type="checkbox"/>	Feeling of hopelessness and no motivation
<input type="checkbox"/>	New migraine headaches
<input type="checkbox"/>	Diminished strength and exercise tolerance
<input type="checkbox"/>	Muscle shrinkage
<input type="checkbox"/>	Joint aches and/or new onset of arthritic symptoms
<input type="checkbox"/>	Dry eyes
<input type="checkbox"/>	Poor balance and coordination
<input type="checkbox"/>	Weight gain
<input type="checkbox"/>	New or increased cellulite
<input type="checkbox"/>	ringing in the ears
<input type="checkbox"/>	Hot flashes and night sweats
<input type="checkbox"/>	Dry vagina or painful intercourse

<input type="checkbox"/>	Dry and wrinkled skin
<input type="checkbox"/>	Height has decreased, osteoporosis or osteopenia
<input type="checkbox"/>	Bladder spasms
<input type="checkbox"/>	Bladder infections
<input type="checkbox"/>	PMS
<input type="checkbox"/>	Felt better when I was pregnant
<input type="checkbox"/>	Cold all the time
<input type="checkbox"/>	Swelling all over the body
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Hair falling out or breaking off
<input type="checkbox"/>	Brittle nails
<input type="checkbox"/>	Stay up for over 24 hours
<input type="checkbox"/>	Difficulty taking oral birth control pills
<input type="checkbox"/>	Other:
<input type="checkbox"/>	
<input type="checkbox"/>	

Birth Control Method (Check all that apply). You must be in menopause, have had a hysterectomy, or use birth control to use pellet therapy

<input type="checkbox"/>	Menopause
<input type="checkbox"/>	Hysterectomy
<input type="checkbox"/>	Tubal ligation
<input type="checkbox"/>	Birth control pills
<input type="checkbox"/>	Abstinence
<input type="checkbox"/>	Vasectomy

<input type="checkbox"/>	Mirena IUD
<input type="checkbox"/>	Other IUD
<input type="checkbox"/>	Other:
<input type="checkbox"/>	
<input type="checkbox"/>	

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Past Surgeries (List year of surgery)

Year	Surgery
	Lap Band Surgery or Obesity Surgery
	Hysterectomy
	Open Heart Surgery
	Joint Replacement
	Cancer Surgery
	Pacemaker
	Removal of ovaries

Habits (Check all that apply)

	Smoking Cigarettes Or Cigars
	I Drink More Than 10 Drinks of Alcohol/Week
	I am a Recovering Alcoholic
	I Use or Have Used Marijuana In Past Year
	I Use or Have Used Cocaine
	I Use or Have Used Heroin

Medical History (Check all that apply)

	Hepatitis or HIV (List Type)
	Breast cancer
	Uterine cancer
	Colon cancer
	Ovarian cancer
	Other cancer
	Blood clot or clotting disorder
	Heart attack
	Stroke
	Vascular disease
	High blood pressure
	High cholesterol
	Heart arrhythmia
	Emphysema (COPD)
	TB (Tuberculosis)
	Glaucoma
	ADD, ADHD
	Depression/Anxiety
	Manic depression (bipolar) or mania
	Schizophrenia
	Leber's Optic Neuritis

	Psychological/psychiatric illness
	Restless leg
	Sleep apnea
	Narcolepsy
	Arthritis
	Rheumatoid arthritis
	Osteopenia or osteoporosis
	Fibro myalgia
	Lupus or autoimmune disease
	Chronic disease
	Chronic fatigue
	Adrenal fatigue
	Multiple sclerosis
	Diabetes type I
	Diabetes type II
	Hypoglycemia
	Insulin Resistance
	Thyroid disease Hypo Hyper
	Addisons disease or Cushings disease
	Kidney disease
	Other

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Exercise History (Check all that apply)

<input type="checkbox"/>	I don't exercise
<input type="checkbox"/>	I have a very physical job so I don't exercise in addition
<input type="checkbox"/>	I exercise every day for ____ minutes
<input type="checkbox"/>	I exercise more than three times a week for over 50 minutes
<input type="checkbox"/>	Normal daily activity is what I consider exercise
<input type="checkbox"/>	I am a long distance runner
<input type="checkbox"/>	I lift weights _____ times a week
<input type="checkbox"/>	Other:
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

Diet (Check all that apply)

<input type="checkbox"/>	I eat anything I want
<input type="checkbox"/>	I don't eat much but gain weight anyway
<input type="checkbox"/>	I have gained weight in my belly since I turned 40
<input type="checkbox"/>	I eat a balanced diet, 3 times a day
<input type="checkbox"/>	I eat 6 small meals a day
<input type="checkbox"/>	I don't eat wheat (gluten intolerance)
<input type="checkbox"/>	I limit carbohydrates
<input type="checkbox"/>	I eat a low fat diet
<input type="checkbox"/>	Atkins/South Beach Diet
<input type="checkbox"/>	Vegan/Vegetarian
<input type="checkbox"/>	Special diet or restrictions
<input type="checkbox"/>	Other:

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Preventative Medical Care (Check all that apply)

<input type="checkbox"/>	Medical/GYN exam in the last year
<input type="checkbox"/>	Mammogram in last 12 months
<input type="checkbox"/>	Bone density in last 12 months (if over 50)
<input type="checkbox"/>	Pelvic ultrasound in last 12 months (If you have a uterus)

Hormone Replacement I have used (Check all that apply)

<input type="checkbox"/>	Oral pills synthetic (Ogen, Premarin, Estrace, etc.)
<input type="checkbox"/>	Patch
<input type="checkbox"/>	Vaginal ring
<input type="checkbox"/>	Other

Bioidentical Hormone replacement I have used (Check all that apply)

<input type="checkbox"/>	Pills
<input type="checkbox"/>	Pellets
<input type="checkbox"/>	Creams/gels applied on the skin or in the vagina
<input type="checkbox"/>	Sublingual or buccal tablets (dissolve in the mouth)

Family History (Check all that apply)

<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Breast Cancer
<input type="checkbox"/>	Uterine cancer
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arrhythmia
<input type="checkbox"/>	Diabetes

<input type="checkbox"/>	Alzheimer's / Dementia any type
<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	Rheumatoid arthritis/Lupus
<input type="checkbox"/>	Thyroid disease — high or low
<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Hemochromatosis

I attest that all the information I give is true.

Print Name: _____

Signature: _____

Date: _____

Consent to Communicate

Please indicate the ways you consent for Alabama Vein & Restoration Medspa to communicate with you

	Can contact (Yes/No)	Can leave message (Yes/No)
Cell Phone		
Home Phone		
Work Phone		
Email		
Text Message		

Do we have permission to speak with spouse/partner? Yes_____ No_____

Do we have permission to leave a message with spouse/partner? Yes_____ No_____

If yes, please list name(s) and relationship _____

Print Name: _____ Signature: _____ Date: _____