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## Patient Information Form-please print

Patient Name			Date of Birth	age
Address			Home phone	
City	State	Zip	Cell Phone	
Email address			Marital status M S W D	Gender M F
Would you like to reco	eive information rega	arding our prod Yes No	uct specials, educational semi	nars and events?
Employer			Phone	
May we contact you at v	vork? Yes No Soci	al Security #		
If under 18:				
Mother/Legal guardian	Name		Phone	
Address				
			Phone	
Address				
How did you hear ab	oout our office?			
Next of Kin/ Emergency	y Contact		Phone	
Please indicate if there	is anything we need to	know to provide	you more personal care	
I realize that skin care all charges.	e is cosmetic and not	covered by ins	urance. I am aware that I an	n responsible for
(p	oatient/parent/guardiar	n signature)	(0	date)
	(witness signatur	re)	(0	date)

 $\square$  I Have Received a Copy of the the Notice of Privacy Practices at Grand Pearl



## **Women's Wellness Consult**

Have you consulted any other physician for this problem? If yes, who?	What is your main concern for to	oday's consult?						
Medications (Prescription)/ what you take them for Supplements/Vitamins (Over the Counter)  Your current Height:	Have you consulted any other ph	ysician for this problem?	If yes, v	who?				
Your current Height:  Your current Weight:  Surgeries/Hospitalizations:  date Have you ever had anesthesia? YN N  date Motion sickness? YN N  date Malignant hyperthermia? YN N  OB/GYN History:  Age of first period/menses: years old  Current frequency and duration of periods: every days, lasting days  First day of last menstrual period:  Do you have any spotting or bleeding between periods? YN N  Do you have any spotting or bleeding after intercourse? YN N  Do you have pain associated with your period? YN N  Are you pregnant or trying to become pregnant? YN N  Are breastfeeding? YN N  Are breastfeeding? YN N  At what age did you go through menopause?  Are you currently sexually active? YN N  What is your current form of birth control?	Allergies/reaction:							
Your current Height:  Your current Weight:  Surgeries/Hospitalizations:  date Have you ever had anesthesia? Y N  date Motion sickness? Y N  date Malignant hyperthermia? Y N  OB/GYN History:  Age of first period/menses: years old  Current frequency and duration of periods: every days, lasting days  First day of last menstrual period:  Do you have any spotting or bleeding between periods? Y N  Do you have any spotting or bleeding after intercourse? Y N  Do you have pain associated with your period? Y N  If you have pain, is it: Before menses During menses Both before & during Are you pregnant or trying to become pregnant? Y N  Are breastfeeding? Y N  Are you menopausal? Y N  At what age did you go through menopause?  Are you currently sexually active? Y N  What is your current form of birth control?	Medications (Prescription)/ wh	at you take them for	Supp	lements/Vi	tamins	(Over the Co	unter)	
Your current Height:  Your current Weight:  Surgeries/Hospitalizations:  date Have you ever had anesthesia? Y N  date Motion sickness? Y N  date Malignant hyperthermia? Y N  OB/GYN History:  Age of first period/menses: years old  Current frequency and duration of periods: every days, lasting days  First day of last menstrual period:  Do you have any spotting or bleeding between periods? Y N  Do you have any spotting or bleeding after intercourse? Y N  Do you have pain associated with your period? Y N  If you have pain, is it: Before menses During menses Both before & during Are you pregnant or trying to become pregnant? Y N  Are breastfeeding? Y N  Are you menopausal? Y N  At what age did you go through menopause?  Are you currently sexually active? Y N  What is your current form of birth control?								
Your current Weight:  Surgeries/Hospitalizations:  date Have you ever had anesthesia? Y N date Motion sickness? Y N date Malignant hyperthermia? Y N date Malignant hyperthermia? Y N date Malignant hyperthermia? Y N N date days, lasting days, lasting days First day of last menstrual period: Do you have any spotting or bleeding between periods? Y N Do you have pain associated with your period? Y N Hiyou have pain, is it: Before menses During menses Both before & during Are you pregnant or trying to become pregnant? Y N Are breastfeeding? Y N At what age did you go through menopause?  Are you currently sexually active? Y N W N Hit is your current form of birth control?		_						-
Surgeries/Hospitalizations:								
Surgeries/Hospitalizations:								
date	Your current Weight:							
date Motion sickness? Y N	Surgeries/Hospitalizations:		A	nesthesia I	History	7:		
		date	Н	lave you eve	er had	anesthesia?	Y	N
		date	N	lausea/Vom	iting a	fter?	Y	N
			Ν	lotion sickn	iess?		Y	N
OB/GYN History:  Age of first period/menses:		•	Ν	Ialignant hy	perthe	rmia?	Y	N
Age of first period/menses: years old  Current frequency and duration of periods: every days, lasting days  First day of last menstrual period:  Do you have any spotting or bleeding between periods? YN  Do you have any spotting or bleeding after intercourse? YN  Do you have pain associated with your period? YN  If you have pain, is it: Before menses During menses Both before & during Are you pregnant or trying to become pregnant? YN  Are you menopausal? YN  At what age did you go through menopause?  Are you currently sexually active? YN  What is your current form of birth control?								
First day of last menstrual period:  Do you have any spotting or bleeding between periods?  Do you have any spotting or bleeding after intercourse?  Y N  Do you have pain associated with your period?  If you have pain, is it: Before menses  Are you pregnant or trying to become pregnant?  Are breastfeeding?  Y N  Are breastfeeding?  Y N  At what age did you go through menopause?  Are you currently sexually active?  Y N  What is your current form of birth control?	•	years old						
Do you have any spotting or bleeding between periods? Y N Do you have any spotting or bleeding after intercourse? Y N Do you have pain associated with your period? Y N If you have pain, is it: Before menses During menses Both before & during Are you pregnant or trying to become pregnant? Y N Are breastfeeding? Y N Are you menopausal? Y N At what age did you go through menopause?  Are you currently sexually active? Y N What is your current form of birth control?	Current frequency and duration of	of periods: every	days	, lasting		_ days		
Do you have any spotting or bleeding after intercourse? Y N Do you have pain associated with your period? Y N If you have pain, is it: Before menses During menses Both before & during Are you pregnant or trying to become pregnant? Y N Are breastfeeding? Y N Are you menopausal? Y N At what age did you go through menopause? Are you currently sexually active? Y N What is your current form of birth control?	First day of last menstru	al period:						
Do you have pain associated with your period?  If you have pain, is it: Before menses Are you pregnant or trying to become pregnant?  Are breastfeeding?  Y N Are you menopausal?  Y N At what age did you go through menopause?  Are you currently sexually active?  Y N What is your current form of birth control?	Do you have any spottin	g or bleeding between peri	ods?	Y	N			
If you have pain, is it: Before menses During menses Both before & during Are you pregnant or trying to become pregnant? YN Are breastfeeding? YN Are you menopausal? YN At what age did you go through menopause?Are you currently sexually active? YN What is your current form of birth control?	Do you have any spottin	g or bleeding after intercou	ırse?	Y	N			
Are you pregnant or trying to become pregnant?  Are breastfeeding?  Y  N  Are you menopausal?  Y  N  At what age did you go through menopause?  Are you currently sexually active?  Y  N  What is your current form of birth control?				Y	N			
Are breastfeeding?  Are you menopausal?  At what age did you go through menopause?  Are you currently sexually active?  What is your current form of birth control?	If you have pain	, is it: Before menses	$\Gamma$	ouring mens	es	Both before	e & duri	ng
Are you menopausal? Y N  At what age did you go through menopause?  Are you currently sexually active? Y N  What is your current form of birth control?	Are you pregnant or tryi	ng to become pregnant?			N			
At what age did you go through menopause? Are you currently sexually active? Y N What is your current form of birth control?	_			Y	N			
Are you currently sexually active? Y N What is your current form of birth control?								
What is your current form of birth control?	At what age did you go t	hrough menopause?		_				
Number of pregnancies: Number of Deliveries:								
	Number of pregnancies:	N	umber o	of Deliveries	s:			_

Do you have a history of:			Have you had:		
Breast Cancer	Y	N	Hysterectomy w/removal of ovaries	Y	N
Uterine/Endometrial Cancer	Y	N	Hysterectomy (ovaries remain)	Y	N
Ovarian Cancer	Y	N	Oophorectomy (removal of ovaries)	Y	N

## **Past Medical History:**

(patient signature) (date)

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Endometriosis	Y	N	Tuberculosis (TB)	Y	N	Blood clots	Y	N
Fibroids/Polyps	Y	N	History of MRSA	Y	N	Stroke	Y	N
Polycystic Ovarian dz	Y	N	Heart Disease	Y	N	Diabetes	Y	N
Fibrocystic Breast dz	Y	N	High Cholesterol	Y	N	Fibromyalgia	Y	N
Acne	Y	N	Heart Attack	Y	N	Keloids	Y	N
Thyroid Disorder	Y	N	Heart Arrhythmia	Y	N	Gastric Surgery	Y	N
HSV (Herpes)	Y	N	High Blood Pressure	Y	N	Bleeding problem	Y	N
AIDS/HIV	Y	N	Seizures	Y	N	Autoimmune dz	Y	N
Hepatitis	Y	N	Concussion	Y	N	Asthma	Y	N

Do you have any of these symptoms? (Check all that apply)

Do you have any of these symptoms. (Chee	K an that apply)			
Symptom	Never	Mild	Mod	Severe
Depressive mood				
Fatigue				
Memory loss				
Mental confusion/Brain "fog"				
Decreased sex drive/libido				
Sleep problems				
Mood changes/irritability				
Migraine/severe headaches				
Difficulty achieving orgasm				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes/Night sweats				
Dry/wrinkled skin				
Hair loss				
Cold intolerance				
Joint pain/Swelling				

I realize that accurate medical information is essential for safe and proper medical care. The above information is true and accurate to the best of my knowledge.

(patient signature) (date)