

Last Name: _____ First Name: _____ MI: _____

Street _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone:(H): _____ (W): _____ Email: _____

Date of Birth: _____ Marital Status: _____ Ethnicity: _____ Ht: _____ Wt: _____

Are You: Pre-menopausal (still having regular menstrual periods)
If yes, what method of birth control (if any) do you use? _____

Peri-menopausal (periods changing, hot flashes, night sweats, mood swings)
If yes, are you taking any hormonal therapy (birth control or hormone replacement)?

Post-menopausal (periods stopped more than 12 months ago or hysterectomized)
If yes, are you being treated with hormone replacement therapy? _____

Do you have any of the following medical conditions? Check all that apply.

- | | | |
|---|---|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Chronic diarrhea |
| <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Frequent nighttime urination | <input type="checkbox"/> Irritable bowel syndrome(IBS) |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Vaginal infections | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Premenstrual syndrome (PMS) | <input type="checkbox"/> Anxiety | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Heart attacks |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Chronic constipation | <input type="checkbox"/> Severe acne |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) | <input type="checkbox"/> Thyroid disorders | |
| | <input type="checkbox"/> Breast pain | |
| | <input type="checkbox"/> Fibrocystic breast disease | |

Have you ever had any of the following? Check all that apply.

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Hysterectomy (removal of uterus) | <input type="checkbox"/> Gall bladder removed | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> One ovary removed | <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> Both ovaries removed | <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Any cancer |
| <input type="checkbox"/> Undiagnosed vaginal bleeding | <input type="checkbox"/> Uterine cancer | |
| | <input type="checkbox"/> Alcohol and/or drug abuse | |

Please list any serious illnesses or major surgeries. _____
