Phone:
Fax:

Return Patient History -

Reason for visit today

☐ **No change in remaining history/medical problems/medications**

Date of Your Last
Menstrual Period:

Menopause History

Age at Menopause:

	Yes / No		Yes / No
Taking Hormone Therapy:	☐ ☐	Night Sweats	☐ ☐
Hot Flashes:	☐ ☐	Painful Intercourse:	☐ ☐
Insomnia:	☐ ☐	Skipping Periods:	☐ ☐
Irregular Bleeding:	☐ ☐	Vaginal Dryness:	☐ ☐

List Current Medications:

Phone:
Fax:

Return Patient History -

List Any Known Allergies:

Pharmacy Name - Preferred:

Pharmacy Name - Mail Order:

Prefer 30 Day Refill: ☐
Prefer 90 Day Refill: ☐

Do you have any of the following problems?

Generalized Symptoms	Yes / No
Anxiety:	☐ ☐
Depression:	☐ ☐
Diabetes:	☐ ☐
Fatigue:	☐ ☐
High Cholesterol:	☐ ☐
Nervousness:	☐ ☐
Seizures:	☐ ☐
Sleep Disorders:	☐ ☐
Stress:	☐ ☐
Substance Abuse:	☐ ☐
Thyroid - Overactive:	☐ ☐
Thyroid - Underactive:	☐ ☐

Urinary	Yes / No
Painful Urination:	☐ ☐
Urinary Incontinence:	☐ ☐

Head / Ear / Nose / Throat	Yes / No
Earaches or Drainage:	☐ ☐
Headache:	☐ ☐
Hearing Loss or Ringing:	☐ ☐
Sinus Problems:	☐ ☐
Vision Changes:	☐ ☐

Respiratory	Yes / No
COPD:	☐ ☐
Shortness of Breath:	☐ ☐
Wheezing:	☐ ☐

Cardiovascular	Yes / No
Chest Pain:	☐ ☐
Congestive Heart Failure:	☐ ☐
Heart Attack:	☐ ☐
Heart Murmur:	☐ ☐

Phone:
Fax:

Return Patient History -

	Yes / No
Urinary Urgency:	❑ ❑

Musculoskeletal	**Yes / No**
Back Pain:	❑ ❑
Joint Pain:	❑ ❑
Muscle Cramps:	❑ ❑

Gynecological	**Yes / No**
Cervical Disease:	❑ ❑
Genital Sores:	❑ ❑
Heavy Bleeding:	❑ ❑
Vaginal Discharge:	❑ ❑
Vaginal Itching:	❑ ❑
Vaginal Odor:	❑ ❑

Hypertension:	❑ ❑

Gastrointestinal	**Yes / No**
Abdominal Pain:	❑ ❑
Constipation:	❑ ❑
Diarrhea:	❑ ❑
Heartburn:	❑ ❑

Do you have any of the following symptoms?

	Yes / No
Bloating:	❑ ❑
Breast Tenderness:	❑ ❑
Cramping:	❑ ❑
Moodiness:	❑ ❑

Social History

Marital Status:

Smoker - Cigarettes per Day:

Alcohol - Drinks per Week:

History of Drug Use:

	Yes / No
Are You Employed?	❑ ❑

Occupation:

Sexual Activity	
Never:	❑
Current:	❑

Partners	
Spouse:	❑
Significant Other:	❑

Phone:
Fax:

Return Patient History -

Past: ☐

Name of spouse/emergency contact

Specify relationship: spouse/parent/friend

Phone number