Lafferty
Family Care
With You. For Life.

FEMALE NEW PATIENT

NAME: _____ DATE OF BIRTH: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____ RACE: _____

CURRENT EMAIL: _____ LAST 4 DIGITS OF SS#: _____

ADDRESS: _____ Zip Code: _____

PHONE: _____ home ( ) cell ( )

HISTORY OF RENAL DISEASE:	YES	NO
HISTORY OF ACTIVE LIVER DISEASE:	YES	NO
HYSTERECTOMY:	YES	NO
OVARIES REMOVED:	YES	NO
HISTORY OF CERVICAL CANCER:	YES	NO
HISTORY OF OVARIAN CANCER:	YES	NO
HISTORY OF BREAST CANCER:	YES	NO
FIBROCYSTIC BREAST CANCER:	YES	NO
HISTORY OF POLYCIYSTIC OVARIAN SYNDROME:	YES	NO
HISTORY OF HEAVY PERIODS/ FIBROIDS:	YES	NO
HISTORY OF METABOLIC SYNDROME:	YES	NO
PREMENOPAUSAL:	YES	NO
MENSTRUAL MIGRAINES:	YES	NO
FLUID RETENTION:	YES	NO
PERSISTENT BREAST PAIN:	YES	NO
ACNE:	YES	NO
FACIAL HAIR:	YES	NO
SIGNIFICANT HAIR LOSS:	YES	NO

EXERCISE:

Sedentary
Exercise 3 days a week
Exercise 5-7 days a week

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IF YOU ARE CURRENTLY TAKING ESTROGEN WHAT IS YOUR DOSAGE AND METHOD:

PATCH_____

PILLS _____

CREAM _____

DO YOU HAVE SYMPTOMS WITH CURRENT HORMONE METHOD: _____YES _____ NO

IF YES WHAT ARE YOUR SYMPTOMS: _____

SYMPTOM CHECKLIST

Please indicate (circle) how often you encounter the following symptoms:

Fatigue	Frequently	Rarely	Never
Night sweats	Frequently	Rarely	Never
Pain with Intercourse	Frequently	Rarely	Never
Vaginal dryness	Frequently	Rarely	Never
Urine leaks when you cough or sneeze	Frequently	Rarely	Never
Muscle pain	Frequently	Rarely	Never
Joint pain	Frequently	Rarely	Never
Poor recovery from exercise	Frequently	Rarely	Never
Poor response from exercise	Frequently	Rarely	Never
Difficulty concentrating	Frequently	Rarely	Never
Foggy thinking	Frequently	Rarely	Never
Loss of memory	Frequently	Rarely	Never
Menstrual migraines	Frequently	Rarely	Never
Depression	Frequently	Rarely	Never
Anxiety	Frequently	Rarely	Never
Mood swings	Frequently	Rarely	Never
Insomnia	Frequently	Rarely	Never
Decrease in sexual desire	Frequently	Rarely	Never
Hot flashes/hot flushes	Frequently	Rarely	Never