Patient Information

Name: _____
Last First Middle

Street Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Cell Phone: _____

Email address: _____

Marital Status: (circle) Single Married Divorced Separated Widow/Widower

Please provide information for someone we may contact in case of an emergency.

Name: _____

Telephone or cell phone: _____

Relationship: _____

Signature: _____

Date: _____

What is the reason for your visit today? Please be as specific as possible.

_____

_____

_____

_____

_____

How did you hear about us?

_____

_____

_____

Do you presently take any hormonal or herbal therapy? Please check all that apply.

◯ Pills _____
medication and dose

◯ Creams _____
medication and dose

◯ Gels _____
medication and dose

◯ Injections _____
medication and dose

◯ Pellets _____
medication and dose

◯ Other / Herbals _____
medication and dose

Current Medications

Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician
Drug name	Dose	Prescribing Physician

Drug Allergies _____

Medical Problems

_____

_____

Previous Surgeries

_____

_____

Social History

Do you smoke tobacco? Yes ◯ No ◯

If yes, how much do you smoke? _____

Do you use recreational drugs? Yes ◯ No ◯

If yes, please list the drugs used: _____

Do you drink alcohol? Yes ◯ No ◯

How many drinks per week: _____

Have you ever had an STD? Yes ◯ No ◯

If yes, please list: _____

Gynecologic History

Who is your Gynecologist? _____

Are you sexually active? Yes ◯ No ◯

What type of contraception are you currently using? (please circle that apply)

Pills IUD Spermicide Condom Tubal ligation Vasectomy

Diaphragm Withdrawal Implant Depo-Provera Patch Vaginal Ring

Date of last Pap smear: _____

Have you ever had an abnormal Pap? Yes ◯ No ◯

How was it treated? _____

Have you had any of the following? ◯ ◯

Uterine cancer Yes ◯ No ◯

Ovarian cancer Yes ◯ No ◯

Breast cancer Yes ◯ No ◯

Other female cancer: _____

Have you ever had a mammogram? Yes ◯ No ◯

Date and results of last mammogram: _____

Have you ever had a breast biopsy? Yes ◯ No ◯

If yes, which side? Left ◯ Right ◯

What were the results? _____

Have you ever been told you have fibroids? Yes ◯ No ◯

If yes please explain, including date and results of ultrasound (if performed):

_____

Do you still have your uterus? Yes ◯ No ◯

If you no longer have periods, please circle the reason:

Natural menopause Hysterectomy Endometrial ablation

Symptom Check List

	Frequently	Rarely	Never
Hot flashes	◯	◯	◯
Night sweats	◯	◯	◯
Pain with intercourse	◯	◯	◯
Vaginal dryness	◯	◯	◯
Sleeping problems	◯	◯	◯
Urine leakage when you cough/sneeze	◯	◯	◯
Difficulty concentrating/memory loss	◯	◯	◯
Foggy thinking	◯	◯	◯
Mood swings	◯	◯	◯
Migraines	◯	◯	◯
Depression	◯	◯	◯
Anxiety	◯	◯	◯
Decrease sexual desire	◯	◯	◯
Decrease in energy level	◯	◯	◯
Muscle or joint pain	◯	◯	◯

Mammogram Waiver for Hormonal Pellet Therapy

I voluntarily choose to undergo implantation of subcutaneous Estradiol and/or Testosterone pellet therapy at the Cincinnati Center for Hormonal Pellet Therapy.

◯ I am current with my mammogram testing.

Date of last mammogram: _____

Results of last mammogram: Normal ◯ Abnormal ◯

◯ For today's visit, I **do not** have a mammogram report for the following reason:

- ◯ My decision not to have one.
- ◯ My physician has not ordered one.
- ◯ Unable to provide report of most recent mammogram.

I am aware that mammograms are integral in the detection of early breast cancer. If I am unable to provide the results of a current mammogram, I acknowledge that I bear full responsibility for any personal injury or illness, accident, risk or loss (including death and/or breast or uterine issues) that may be sustained if I do not routinely get mammograms.

_____ _____

Signature Date