



Bio Identical Hormone Replacement
Achieving Hormone Balance Naturally

FEMALE PATIENT INFORMATION

Today's Date: _____

Name: _____
FIRST MIDDLE LAST

Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

Cell Number: _____

Email address: _____

YOUR EMAIL ADDRESS IS DR. DE LA TORRE'S PREFERRED MEANS OF CONTACTING YOU

Marital Status (please circle): MARRIED DIVORCED SINGLE WIDOW
LIVING WITH SIGNIFICANT OTHER

In case of an emergency, whom should we notify?

Contact Name: _____ Relationship: _____

Contact Information: _____
HOME TELEPHONE CELL PHONE

EMAIL ADDRESS

Signature: _____ Date: _____

Please state the reason(s) for your visit and describe the symptoms you are experiencing:

How did you hear about us?

Please circle: Friend Newspaper Internet Other

Please remember that insurance does not cover the consult visit or procedure. We expect that our charges for the office visits are paid at the conclusion of each visit.

I authorize the release of information from my primary care physician or specialist if deemed necessary for treatment.

Signature: _____ Date: _____

SYMPTOM CHECKLIST

**Please circle the symptoms you are experiencing
And the frequency or severity of symptoms:**

Night sweats:	<3 times/week	1-3 times/night	>3times/night	
Sleeping problems:	Never	1-3 times/night	Nightly	
Hot flashes/hot flushes:	Never	1-3 flashes/week	Daily/Nightly	
Decrease in sexual desire:	Not a problem	No Desire		
Pain with intercourse:	Never	Only on occasion	Almost always	
Vaginal dryness:	Never	Only on occasion	Almost always	
Urine leaks when you cough or sneeze:	Never	Occasionally	Always	
Difficulty concentrating:	Not a problem	Getting worse		
Memory loss:	Not a problem	Getting worse		
Foggy thinking:	Not a problem	Getting worse		
Decrease in energy level:	Not a problem	Getting worse		
Mood swings:	Never	Getting worse		
Migraines or Headaches:	Never	Occasionally	More often	Daily
Depression:	Rarely	Occasionally	More often	Daily
Anxiety:	Never	Occasionally	More often	Daily
Muscle pain:	Never	Occasionally	More often	Daily
Joint pain:	Never	Occasionally	More often	Daily

Are you taking prescription medication for any of the symptoms above? YES NO

Please list the medications: _____

Are you taking herbal medications/supplements for symptoms? YES NO

Please list the medications: _____



GYN HISTORY:

1. Number of Pregnancies: _____
Number of Live Births: _____
Number of Miscarriages: _____

2. Do you have any uterine abnormality such as fibroids? YES NO
Please describe: _____

3. Do you have a history of infertility? YES NO

4. Do you have a history of DES exposure? YES NO

5. Are you **currently having periods**? YES NO
If YES, please answer the following questions. **If NO, please skip to question 6.**
Date of last period: _____
How many days do your periods typically last? _____
Are your periods regular? YES NO
How many days between periods? _____
Has the flow of your period changed in any way? YES NO
Please explain: _____
Does bleeding occur between your normal period cycle? YES NO
Do you have menstrual cramps? YES NO
List the medications you take for cramps: _____
Do you have PMS? YES NO

6. If you **no longer have periods**, circle the reason:
Hysterectomy Ablation Menopause
In what year and at what age did you start menopause? _____

7. What type of contraception are you currently using (circle all that apply)?
NONE Pills IUD Foam Condoms Tubal Ligation
Vasectomy Diaphragm Withdrawal Implants Depo Provera

8. What type of contraction have you used in the past (circle all that apply)?
Pills IUD Foam Condoms Tubal Ligation
Vasectomy Diaphragm Withdrawal Implants Depo Provera

9. Have you had any vaginal, cervical, and/or fallopian tube infections? YES NO
If YES, circle all that apply:
Gardnerella Syphilis Condylomata Bacterial Vaginitis
Yeast PID Herpes Chlamydia Gonorrhea

10. Date of last Pap smear: _____

11. Have you ever had an abnormal Pap Smear? YES NO
If YES, now was it treated (circle all that apply):

Repeated Pap smear
Cryosurgery (freezing)

Colposcopy
Cone Biopsy

Laser Surgery
Hysterectomy

12. Date of last Mammogram: _____ Was it NORMAL? YES NO

13. Do you have any breast lumps, tenderness or discharge? YES NO

14. Do you perform self breast exams? YES NO

15. Are you using any form of **HORMONE THERAPY**? YES NO

Please circle which type:

Gel Cream Shots Pellets Other

MEDICAL HISTORY:

16. Current Weight: _____

17. List drug allergies: _____

18. Do you have a Family Physician or Internist? YES NO

Please list the name of the physician and a number where they may be reached:

Physician Name: _____ Phone Number: _____

19. List the medications you are currently taking and the dosage amount:

20. Do you have or have you been treated for the following:

Acne	YES	NO
Anemia	YES	NO
Anxiety	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Blood clots in the leg or lungs	YES	NO
Bloating	YES	NO
Blood transfusion	YES	NO
Chronic Bronchitis	YES	NO
Chronic Fatigue Syndrome	YES	NO
Colon Polyps	YES	NO
Depression	YES	NO
Diabetes	YES	NO
Emphysema	YES	NO

Excessive facial hair growth	YES	NO
Fibromyalgia	YES	NO
Hair Loss	YES	NO
Heart Disease	YES	NO
Heart Attack	YES	NO
Heart Murmur	YES	NO
Hepatitis	YES	NO
If yes, circle which type:	Hepatitis A	B C Other
High cholesterol or triglycerides	YES	NO
Hypertension	YES	NO
Irritable Bowel Syndrom	YES	NO
Kidney Disease	YES	NO
Liver Disease	YES	NO
Lupus	YES	NO
Mitral Valve Prolapse	YES	NO
Osteopenia	YES	NO
Osteoporosis	YES	NO
Rheumatic Fever	YES	NO
Thyroid	YES	NO
If yes, circle which type:	Hypothyroid	Hyperthyroid Goiter Hashimotos
Varicose Veins	YES	NO

21. Are you currently being treated or have been treated for Cancer? YES NO

Please circle which cancer:

- Leukemia
- Lymphoma
- Colon Cancer
- Multiple Myeloma
- Lung Cancer
- Breast Cancer

Please circle the type of treatment received:

- Lumpectomy**
- Mastectomy**
- Radiation**
- Chemotherapy**

Uterine Cancer

Please circle the type of treatment received:

- Hysterectomy**
- Radiation**
- Chemotherapy**

Thyroid Cancer

22. List all major surgeries:

23. List any other operations or hospitalizations (including year and reason):

24. Do you smoke? YES NO
Age you started smoking: _____ Number of cigarettes per day _____

25. Do you drink alcohol? YES NO
On the average, how many drinks per week? _____

26. Do you use recreational drugs? YES NO
How often? _____

FAMILY MEDICAL HISTORY:

Breast YES NO Family member: _____

Colon Cancer YES NO Family member: _____

Ovarian Cancer YES NO Family member: _____

Osteoporosis YES NO Family member: _____

Diabetes YES NO Family member: _____

Hypertension YES NO Family member: _____

Heart Disease YES NO Family member: _____

Patient Signature

Date

Rebecca de la Torre, MD

Date reviewed
