



**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.

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How did you hear about us?

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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

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Drug name	Dose	Prescribing Physician
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Drug name	Dose	Prescribing Physician
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Drug name	Dose	Prescribing Physician
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Drug name	Dose	Prescribing Physician
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## Drug Allergies

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## Medical Problems

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## Previous Surgeries

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## 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Night sweats	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain with intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sleeping problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Urine leakage when you cough/sneeze	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty concentrating/memory loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foggy thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood swings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decrease sexual desire	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Decrease in energy level	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Muscle or joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 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