AESTHETICS & WEIGHTLOSS

New Patient Hormones: Female

Patient Name:_____ Date:_____

DOB:_____ Age:_____ Height:_____ Weight: _____

Race: _____ Date of Last Menstrual Period:_____ Number of Pregnancies:_____

Number of Live Births:_____ Abortions/Miscarriages: _____

History of Renal Disease: Yes / No

Active Liver Disease: : Yes / No

History of Breast Cancer: Yes / No *If yes: (self or family)*

History of Cervical Cancer: Yes / No

History of Ovarian Cancer: Yes / No

Hysterectomy: Yes / No Year:_____

Acne: Yes / No

Facial Hair: Yes / No

Hair Loss: Yes / No

History of PCOS: Yes / No

History of Heavy Menses/Fibroids: Yes / No

History of Metabolic Syndrome: Yes / No

Pre-Menopausal: Yes / No

Menstrual Migraines: Yes / No

Difficulty Losing Weight: Yes / No

Fibrocystic Breast Disease: Yes / No

OB/GYN Physician:_____

Previously Received Hormones: Yes / No

Date of Last PAP:_____

If yes, Where:_____

Year of Last Mammogram:_____

Date:_____

Pellets: Yes / No

AESTHETICS & WEIGHTLOSS

New Patient History

Name:_____ Date:_____

DOB:_____ Age:_____

Please complete the following form. This information will assist us in your evaluation today.

Name of Primary Care Physician:_____

Medical History:

1. List current medications including prescription medications, vitamins, herbals or diet supplements and any over-the-counter medications. List the dosage and the dates started. Attach medication list if you have one. _____

   _____

   _____

   _____

2. List any allergies and the reactions to the allergy. _____

   _____

   _____

3. Past medical problems and dates of problems: (hypertension/diabetes) _____

   _____

4. Past surgeries and dates of each surgery: _____

   _____

5. Please circle below if you are experiencing any of the following symptoms:

Fatigue Weight Gain Decreased Libido Hot Flashes Night Sweats Acne Hair Growth

Social History:

1. Do you currently smoke? Y / N
2. Did you previously smoke? Y / N
3. Do you currently drink alcohol? Y / N
4. Did you previously drink alcohol? Y / N
5. Do you currently use recreational drugs? Y / N
6. Have you ever used recreational drugs? Y / N
7. Do you exercise? Y / N *If yes:* How often per week _____