Simmon L. Wilcox M.D. - FAAEM (Female)

Patient Health & Lifestyle Questionnaire

PATIENT INFORMATION:

Last Name: ______________________ First Name: ______________________

Street Address: ______________________

City: ______________ State: ______________ Zip Code: ______________________

Home Phone: ______________________ Work or Cell Phone: ______________________

Date of Birth: ______________________ Gender: ❑ Male ❑ Female

Height: ______________________ Weight: ______________________

Occupation: ______________________ 9.A U].

METHOD OF PAYMENT:

Credit Card: ❑ Visa ❑ MasterCard ❑ Check ❑ Other: *(Please Specify Below)*

Credit Card Holder: ______________________ ______________________

Credit Card number: ______________________ Expiration Date (mm/yy): ______________________

Whom may we thank for your referral? ____

Please Answer All Questions

If you don't know the answer to a required question, simply state that you don't know.

How did you hear about bioidentical/natural hormone replacement? ____

____

What are your goals for therapy? ____

____

LIFESTYLE INFORMATION:

Do you use tobacco (smoke, chew, dip)? ❑ Yes ❑ No If yes, how often and how much?

____

Do you drink alcohol (beer, wine, hard liquor)? ❑ Yes ❑ No If yes, how often and how much?

____

Do you drink caffeine (cola drinks, tea, coffee)? ❑ Yes ❑ No If yes, how often and how much?

____

Do you exercise regularly? ❑ Yes ❑ No If yes, describe what you do and how often:

____

Do you practice any stress management techniques? ❑ Yes ❑ No If yes, describe what you do and how often:

____

DIET: Describe Your Typical Daily Food Intake:

Breakfast: ______

Lunch: ______

Dinner: ______

Other/Snacks: ______

Are you currently dieting or using diet pills? ❑ Yes ❑ No

What kind of diet? ______

DOCTOR INFORMATION:

Are you currently under the care of a physician? ❑ Yes ❑ No

If yes, please list each doctor from whom you seek care, including address and phone number, if known

Doctor Name #1: ______ Doctor Name #2: ______

Address: ______ Address: ______

Phone: ______ Phone: ______

Allergies: *Please check all that apply*

❑ None
❑ Morphine
❑ Codeine
❑ Aspirin
❑ Penicillin
❑ Pet Allergies
❑ Sulfa Drug
❑ Nitrate Allergy
❑ Seasonal Allergies (pollen)
❑ Food Allergies
❑ Dye Allergies
❑ Other: ______

If applicable, please describe any allergic reaction and when it occurred: ______

______

Over-The-Counter Medications: *Please check all products that you use occasionally or regularly*

❑ Pain reliever
❑ Aspirin
❑ Acetaminophen (ex: Tylenol®)
❑ Ibuprofen (ex: Motrin IB®)
❑ Naproxen (ex: Aleve®)
❑ Ketoprofen (ex: Orudis KT®)
❑ Cough suppressant (ex: Robitussin DM®)
❑ Antacids (ex: Maalox®, Mylanta®)
❑ Decongestant (ex: Sudafed®)
❑ Combination (cough-cold reliever) (ex: Triaminic DM®)
❑ Antihistamine (ex: Chlor-Trimeton®)
❑ Sleep aids (ex: Excedrin PM®, Unisom®, Sominex®, Nytol®)
❑ Diarrhea meds: (ex: Imodium®, Pepto Bismol®, Kaopectate®)
❑ Laxatives/stool softeners (ex: Doxidan®, Correctol®)
❑ Diet aids/weight loss products (ex: Dexatrim®)
❑ Acid blockers (ex: Tagamet HB®, Pepcid AC®, Zantac 75®)
❑ Others (please list): ______

Nutritional/Natural Supplements: *Please identify and list the products you are using:*

❑ Vitamins (ex: multiple or single vitamins such as B complex, E, C, beta carotene)
❑ Minerals (ex: calcium, magnesium, chromium, colloidal minerals, various single minerals)
❑ Herbs (ex: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
❑ Enzymes (ex: digestive formulas, papaya, bromelain, CoEnzymeQ10, etc.)
❑ Nutrition/protein supplements (ex: shark cartilage, protein powders, amino acids, fish oils, etc.)
❑ Others (ex: glucosamine, etc.)

______

______

______

Prescription Medications:

Medication Name/Dose/# of times daily/# of times /week

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

TESTS:

Have you ever had any of the following tests performed? Check those that apply and note date of last test.

Mammography ❑ Yes ❑ No Date of test and result: ______________

PAP Smear ❑ Yes ❑ No Date of test and result: ______________

Have you ever had an abnormal PAP smear? ❑ Yes ❑ No What treatment was done? ______________

Pelvic exam ❑ Yes ❑ No Date of test and result: ______________

List details about any other abnormal tests: ______________

When did you last have your cholesterol checked? ______________ Results: ______________

Do you have any lab test results that you can provide from your last physical with your doctor? ❑ Yes ❑ No

(If yes, please bring copies with you to the appointment or fax to our office)

Have you ever had a bone density scan? ❑ Yes ❑ No If yes, when? ______________ Results: ______________

Hormones:

Are you now or have you ever taken hormones (natural or synthetic) previously? If so please list:

Hormone: ______________ Date started: ______________ Date stopped: ______________

Why: ______________

Hormone: ______________ Date started: ______________ Date stopped: ______________

Why: ______________

Hormone: ______________ Date started: ______________ Date stopped: ______________

Why: ______________

Menstrual Cycle History, Past and Present:

Since you first began having periods, have you ever had what you would consider to be abnormal cycles?

❑ Yes ❑ No Date of Cycle: ______________

If Yes, please explain (such as age, when this occurred, symptoms, etc.)

When was your last period? ______________ How many days did it last? ______________

How many days from the start of one period to another? ______________

How many days of bleeding? ______________

Do you have, or did you ever have Premenstrual Syndrome? ❑ Yes ❑ No

If yes, please describe symptoms: ______________

____

When do the symptoms start? ______________ When do they end? ______________

Do you experience cramping? ❑ Yes ❑ No

If yes, please describe: ______________

____

Have you experienced recent changes in your normal cycle? ❑ Yes ❑ No

If yes, please describe: ______________________________

____

Do you experience any bleeding between periods? ❑ Yes ❑ No

Do you experience any:

Pelvic Pain? ❑ Yes ❑ No

If yes, please describe: ______________________________

____

Pelvic Pressure? ❑ Yes ❑ No

If yes, please describe: ______________________________

____

Fullness? ❑ Yes ❑ No

If yes, please describe: ______________________________

____

Sexual Health Profile

Are you emotionally and physically satisfied with your sexuality?

If not, would you like Dr. Navar to address this issue at your appointment?

Contraceptives ❑ Yes ❑ No

If yes, please answer the following questions:

Oral Contraceptive Used? ____________ Date Started: ____________ Date Stopped: ____________

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Oral Contraceptive Used? ____________ Date Started: ____________ Date Stopped: ____________

How many pregnancies have you had? ____________

How many children? ____________

Any Complications? ____________

Any interrupted pregnancies? ____________ If yes, how many? ____________

Have you had a hysterectomy? ❑ Yes ❑ No Date of Surgery? ____________

Have you had your ovaries removed? ❑ Yes ❑ No Date of Surgery? ____________

Are your ovaries intact? ❑ Yes ❑ No Date of Surgery? ____________

Have you had tubal ligation? ❑ Yes ❑ No Date of Surgery? ____________

Family History: Do you have a family history of any of the following?

Uterine Cancer	❑ Yes	❑ No	Relationship: ______
Ovarian Cancer	❑ Yes	❑ No	Relationship: ______
Blood Clots	❑ Yes	❑ No	Relationship: ______
Breast Cancer	❑ Yes	❑ No	Relationship: ______
Heart Disease	❑ Yes	❑ No	Relationship: ______
Osteoporosis	❑ Yes	❑ No	Relationship: ______
Diabetes	❑ Yes	❑ No	Relationship: ______

Symptoms:

Please rate the following symptoms: 0 = Rarely a Problem, 1 = Mild, 2 = Moderate, 3 = This is serious for me

___ Difficulty Concentrating	___ Vaginal Dryness	___ Loss of Pubic Hair	___ Difficulty Sleeping
___ Night Sweats	___ Yeast Infections	___ Low Body Temperature	___ Unable to reach orgasm
___ Headache	___ Moodiness	___ Hair loss	___ Body pain
___ Heart Palpitations	___ Uterine Fibroids	___ Hot Flashes	___ Urinary Tract Infections
___ Fibrocystic Breasts	___ Tender Breasts	___ Leaky bladder	___ Foggy Thinking
___ Feeling of Depression	___ Sugar/Food Cravings	___ Painful Intercourse	___ Memory loss
___ Anxiety	___ Bloating	___ Fatigue	___ Low libido
___ Weight Gain	___ Dry Hair or Skin	___ Increased Facial Hair	___

Any other symptoms not listed: ______

______

Almost Done!
--Last Page Below ---

MEDICAL HISTORY:

List any medical problems that other doctors have diagnosed:
(ie. heart disease, high blood pressure, blood clots, stroke, liver or kidney problems, diabetes, epilepsy, fibromyalgia chronic fatigue syndrome, gallstones, depression, hypothyroidism, prostate cancer, breast or other cancers)

Past Surgeries:

Past Hospitalizations:

Do you have treated or untreated high blood pressure?

Have you ever had a blood transfusion?

Have you ever had a significant head injury?

Have you ever had a blood clot of the lower legs or lung?

Have you ever given yourself street drugs with a needle?

Please ask any questions you may have about Natural Hormone Replacement Therapy, other medications or nutritional supplements, any other questions that come up as you read through the materials you have received.

Please return the completed questionnaire prior to your appointment. Thank you

Additional Questions:

RESET FORM

EMAIL FORM