Female Patient Information

Name:____

Last First Middle

Today's Date:________________________

Date of Birth:________________________ Social Security #:_________________________

Address:____

City:________________________________ State:_________ Zip Code:_________________

Phone Numbers: Home:_______________________ Cell:___________________________

E-mail Address for office use only will not be shared:________________________________

Patient employed by:____

Business Address:____

Business Phone:____

Marital Status:(Please circle) Married Divorced Single Widow Living with significant other

Spouse's Name:____

Spouse's Date of Birth:_____________________Social Security #: _____________________

Spouse employed by:____________________________ Business Phone:_________________

In case of emergency, whom should we notify:_______________________________________

Emergency Phone Numbers:____

Is it ok to leave a message with lab work results on your voice-mail: (please circle) Yes No

What phone number would you like us to call with lab results and/or appointment reminders?

Phone #: _____________________________________

*****Payment is due at time of service.*****

Payment types accepted: Cash, Check, Visa, Mastercard, Discover and American Express

What is your primary health concern or reason for this appointment ?

OB / GYN HISTORY

1. Are you sexually active? ☐ Yes ☐ No
2. Have you been sexually active? ☐ Yes ☐ No
3. Do you have pain with intercourse? ☐ Yes ☐ No
4. Are you now or have you in the past used contraception? ☐ Yes ☐ No

   If yes, what form:______________________________

5. Dates of last pap smear:______________________________
6. Have you ever had abnormal pap smears? ☐ Yes ☐ No

   If yes, how was it treated? Please check below:

   ☐ Repeated Pap Smear ☐ Colposcopy ☐ Laser Surgery ☐ Cone Biopsy

   ☐ Cryosurgery (freezing) ☐ Hysterectomy ☐ Loop Incision

7. Have you had a mammogram? ☐ Yes ☐ No

   If yes, was it normal? ☐ Yes ☐ No

   Date of last mammogram:______________________________

8. Do you have any breast lumps, tenderness or discharge? ☐ Yes ☐ No
9. Do you have any PMS symptoms? ☐ Yes ☐ No

   If yes, any treatment?______________________________

10. Do you have any hot flashes or menopausal symptoms? ☐ Yes ☐ No
11. Do you have any uterine anomalies? ☐ Yes ☐ No
12. If you no longer have periods, please state reason:______________________________
13. Are your periods regular? ☐ Yes ☐ No
14. Do you have any bleeding between periods? ☐ Yes ☐ No
15. Do you have any cramping with your periods? ☐ Yes ☐ No

    If yes, circle one: mild moderate severe

16. Medicine taken for cramps?______________________________

17. Do you have problems leaking urine? ☐ Yes ☐ No

18. Do you have:

Fatigue? ☐ Yes ☐ No

Decrease of memory? ☐ Yes ☐ No

Decrease of energy level? ☐ Yes ☐ No

Decrease of sexual drive? ☐ Yes ☐ No

19. Do you suffer from:

Anxiety? ☐ Yes ☐ No

Irritability? ☐ Yes ☐ No

Mood swings? ☐ Yes ☐ NO

Migraines? ☐ Yes ☐ No

20. How have you dealt with these symptoms?

____

____

____

____

21. Is your sex drive the same as it was five years ago? ☐ Yes ☐ No

Describe:____

22. List any other sexual dysfunctions:

____

____

____

23. Have you experienced weight gain in the last one - two years? ☐ Yes ☐ No

If yes, why?____

24. Have you lost greater than 10 pounds in less than a month? ☐ Yes ☐ No

If yes, why?____

25. List current medications:

____

____

____

____

26. How often does your doctor recommend that you have a Pap smear?

    ____

27. How often does your doctor recommend that you have a mammogram?

    ____

PAST MEDICAL HISTORY

1. Do you have diabetes? ☐ Yes ☐ No
2. Do you have/had hypertension? ☐ Yes ☐ No
3. Do you have heart disease? ☐ Yes ☐ No
4. Do you have a heart murmur? ☐ Yes ☐ No
5. Do you have/had kidney disease? ☐ Yes ☐ No
6. Have you ever been treated for psychiatric problems? ☐ Yes ☐ No
7. Have you ever had rheumatic fever? ☐ Yes ☐ No
8. Do you have mitral valve prolapse? ☐ Yes ☐ No
9. Have you ever had a urinary tract infection? ☐ Yes ☐ No
10. Have you ever had hepatitis/liver disease? ☐ Yes ☐ No
11. Have you ever had varicosities/phlebitis? ☐ Yes ☐ No
12. Do you have any thyroid problems? ☐ Yes ☐ No
13. Have you had any major accidents? ☐ Yes ☐ No
14. Have you ever had any blood transfusions? ☐ Yes ☐ No
15. Do you have asthma/lung disease? ☐ Yes ☐ No
16. Do you have lupus, Scleroderma or similar diseases? ☐ Yes ☐ No

    If yes, please describe:____

17. Do you have arthritis? ☐ Yes ☐ No

    If yes, what type:____

18. Do you have any Drug Allergies? ☐ Yes ☐ No

    If yes, please list:____

19. List any surgeries:

    ____

    ____

    ____

20. List any other operations/hospitalizations (include year & reason):

    ____

    ____

    ____

21. Have you had any anesthesia complications? ☐ Yes ☐ No

    If yes, please list:____

22. Have you ever been anemic? ☐ Yes ☐ No

23. Do you have an Internist or Family Doctor? ☐ Yes ☐ No

    If yes, please list name and phone number:____________________________

24. Have you had your cholesterol checked? ☐ Yes ☐ No

    If yes, date last checked:____________________________________

    Was it normal? ☐ Yes ☐ No

SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ Yes ☐ No

   If yes, number per day?____________________ Number of years?____________

2. Do you drink alcohol? ☐ Yes ☐ No

   If yes, how much per day?____________________________________

FAMILY HISTORY

1. Do you have a family history of breast cancer? ☐ Yes ☐ No

   If yes, whom?____

2. Do you have a family history of colon cancer? ☐ Yes ☐ No

   If yes, whom?____

3. Do you have a family history of ovarian cancer? ☐ Yes ☐ No

   If yes, whom?____

4. Do you have a family history of osteoporosis? ☐ Yes ☐ No

   If yes, whom?____

5. Do you have a family history of diabetes? ☐ Yes ☐ No

   If yes, whom?____

6. Do you have a family history of hypertension? ☐ Yes ☐ No

   If yes, whom?____

7. Do you have a family history of heart disease? ☐ Yes ☐ No

   If yes, whom?____

8. Do you have a family history of kidney disease? ☐ Yes ☐ No

   If yes, whom?____

FEMALE
SYMPTOM CHECKLIST

Name: ____ Date: _______________

Which of the following symptoms apply to you at this time? Please mark the appropriate oval for each symptom.

		Frequently	Rarely	Never
1.	**Hot flashes, sweating**	☐	☐	☐
2.	**Night Sweats**	☐	☐	☐
3.	**Depression**	☐	☐	☐
4.	**Irritability**	☐	☐	☐
5.	**Anxiety**	☐	☐	☐
6.	**Decreased energy**	☐	☐	☐
7.	**Decreased sexual desire**	☐	☐	☐
8.	**Urine leakage when you cough/sneeze**	☐	☐	☐
9.	**Vaginal dryness**	☐	☐	☐
10.	**Pain with Intercourse**	☐	☐	☐

11.	Muscle or joint pain	☐	☐	☐
12.	Sleeping Problems	☐	☐	☐
13.	Difficulty concentrating	☐	☐	☐
14.	Foggy thinking	☐	☐	☐
15.	Mood swings	☐	☐	☐
16.	Migraines	☐	☐	☐
17.	Decreased stamina	☐	☐	☐
18.	Irregular menstruation	☐	☐	☐
19.	Cold body temperature	☐	☐	☐
20.	Difficulty losing weight	☐	☐	☐
21.	Elevated triglycerides	☐	☐	☐
22.	Elevated cholesterol	☐	☐	☐

Do you have any other major symptoms? **Yes** ☐ **No** ☐

If yes, please describe:

____

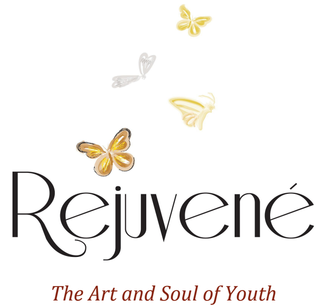
____

____

____

____

____



Acknowledgement of Rejuvene's Policy on Insurance Billing

Unlike most medical practices, Rejuvene does not have an insurance or billing department. Because we have chosen to not engage in insurance or patient billing, we do not have to carry the expense that an insurance/patient billing department incurs - an expense that is ultimately passed down to the patient. This is why we require payment at the time of service.

As a patient of Rejuvene, you are free to submit your own claim to your insurance provider, although in our experience, common insurance providers do not reimburse for BHRT. Most insurance companies are used to reimbursing claims to the physician practice, and therefore make many inquires directly to the physician, requesting medical records and other documentation. Because we do not have an insurance/billing department to handle these requests, we leave the management of your claim to you. If you need copies of your medical records to assist your insurance provider in processing your claim, we are happy to assist you upon receipt of a written request from you our patient (please allow 7-10 days for processing).

I acknowledge that I have reviewed the above stated policy.

Patient Signature **Date**