2210 W Kingshighway Suite 7
Paragould, AR 72450

Name:_____ DOB:_____

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

DOB: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Preferred Contact Number: _____

May we send messages via text regarding appointments to your cell? _____Yes _____No

Email address: _____ May we contact you via email? ____Yes ____No

In case of emergency contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary care physician's name: _____ Phone: _____

Address:
_____

Marital Status (check one): ____Married ____Divorced ____Widow ____Living with partner ____Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Name: _____ Relationship:_____

Home Phone: _____ Cell Phone: _____ Work: _____

SOCIAL:

____ I am sexually active.	OR	____ I want to be sexually active.	____ I do not want to be sexually active.
____ I have completed my family.	OR	___ I have NOT completed my family.	
____ My sex life has suffered.	OR	____ I have not been able to have an orgasm or it is very difficult.	

HABITS:

____ I smoke cigarettes or cigars ___ per day.	____ I use e-cigarettes ___ a day.	____ I use caffeine ___ a day.
____ I drink alcoholic beverages ___ per week.	____ I drink more than 10 alcoholic beverages a week.	

2210 W Kingshighway Suite 7
Paragould, AR 72450

Name:_____ DOB:_____

FEMALE PATIENT QUESTIONNAIRE & HISTORY (continued)

DRUG ALLERGIES:

Drug Allergies: _____ If yes, please explain: _____

Have you ever had any issues with local anesthesia? ____ Yes. ____No. Do you have a latex allergy? ____Yes ____No

Medications currently taking: _____

Current hormone replacement? ____Yes. ____No. If yes, what?_____

Past hormone replacement therapy: _____

FAMILY HISTORY:

____HEART DISEASE____DIABETES_____OSTEOPOROSIS____ALHEIMER'S/DEMENTIA____BREAST CANCER____OTHER_____

PERTINENT MEDICAL/SURGICAL HISTORY:

____Breast Cancer

____Uterine Cancer

____Ovarian Cancer

____Polycystic ovaries (PCOS)

____Acne

____Excess facial/body hair

____Infertility

____Endometriosis

____Epilepsy or seizures

____Fibrocystic breast or breast pain

____Uterine fibroids

____Irregular or heavy periods

____Menstrual Migraines

____Hysterectomy with removal of ovaries

____Partial hysterectomy (uterus only)

____Ophorectomy removal of ovaries only

BIRTH CONTROL METHOD:

____Menopause

____Hysterectomy

____Tubal ligation

____Birth control pills

____Vasectomy

____IUD

____Infertility

____Other _____

2210 W Kingshighway Suite 7
Paragould, AR 72450

Name:_____ DOB:_____

FEMALE PATIENT QUESTIONNAIRE & HISTORY (continued)

MEDICAL HISTORY:

____High blood pressure or hypertension

____Heart disease

____Atrial fibrillation or other arrythmia

____Blood clot and/or pulmonary embolism

____Depression/anxiety

____Chronic liver disease (hepatitis, fatty liver, cirrhosis)

____Arthritis

____Hair thinning

____Sleep apnea

____High cholesterol

____Stroke and/or heart attack

____HIV or any other type of hepatitis

____Hemochromatosis

____Psychiatric disorder

____Thyroid disease

____Diabetes

____Thyroid disease

____Lupus or other autoimmune disease

____Other _____

BioTe

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

Name:_____ DOB:_____

Email: _____ Phone number: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical exhaustion (fatigue, lack of energy, stamina, or motivation)	☐	☐	☐	☐	☐
Sleep problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, panicky, or nervous)	☐	☐	☐	☐	☐