Rejuve HEALTH CLINICS

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Female Patient History & Questionnaire
Bioidentical Hormone Replacement Therapy

First Name	Middle Initial	Last Name
Address		
City	State	Zip Code
DOB	Height	Weight
Email Address	Emergency Contact Name	Emergency Contact Phone Number
Home Phone	Work Phone	Cell Phone
Primary Care Provider	Phone Number	Date of last physical exam

What brings you in to see us today? ____

How did you hear about Rejuve? ☐ Web Search ☐ Facebook ☐ Friend/Family ☐ Instagram ☐ Other ________

May we send you a text message to remind you of your appointment? ☐ **YES** ☐ **NO**

May we contact you by email? ☐ **YES** ☐ **NO**

Medication History

List all **Prescription Medications** and dosages you are currently taking:	
1.	4.
2.	5.
3.	6.

List all **Vitamins, Supplements, Over the Counter Medications** and dosages you are currently taking:	
1.	5.
2.	6.
3.	7.

List all **Past Hormone Medications and/or Birth Control** with dosages & approximate start / stop dates:	
1.	5.
2.	6.
3.	7.

Report of Medical History

Do You Have Allergies to Medications? ☐ **YES** ☐ **NO** If **YES**, please list below:	
1.	4.
2.	5.
☐ **YES** ☐ **NO** Do you Smoke?	If **YES**, how many cigarettes per day:
For how many years have you smoked?	
☐ **YES** ☐ **NO** Do you drink alcohol?	If **YES**, how many drinks per week:
☐ **YES** ☐ **NO** Have you had a hysterectomy? If **YES**, date of hysterectomy: _____ / _____ / _____	Full or partial hysterectomy? Reason for hysterectomy?
☐ **YES** ☐ **NO** Are you pregnant? ☐ **YES** ☐ **NO** Are you attempting to conceive?	☐ **YES** ☐ **NO** Are you breastfeeding?
☐ **YES** ☐ **NO** Are you still menstruating?	If **YES**, date of last period: _____ / _____ / _____
☐ **YES** ☐ **NO** Have you given birth?	If **YES**, how many births?
☐ **YES** ☐ **NO** Have you experienced a miscarriage?	If **YES**, how many miscarriages?
☐ **YES** ☐ **NO** Have you had a tubal ligation?	If **YES**, date of tubal ligation**:** _____ / _____ / _____
Date of last pap smear: _____ / _____ / _____	☐ **YES** ☐ **NO** Have you had an abnormal pap smear? If **YES**, provide date & details: ____ / ____ / ____
☐ **YES** ☐ **NO** Have you had a mammogram? If **YES**, date of mammogram**:** _____ / _____ / _____	☐ **YES** ☐ **NO** Have you had abnormal mammogram? If **YES**, provide date & details: ____ / ____ / ____

Medical History Continued:

Have you ever, or do you now have:											
YES	NO	Don't Know	(PLEASE CHECK EACH)	YES	NO	Don't Know	(PLEASE CHECK EACH)	YES	NO	Don't Know	(PLEASE CHECK EACH)
			Scarlet fever, erysipelas				Leg cramps				STIs - chlamydia/HSV/etc
			Rheumatic fever				Frequent indigestion				HIV / AIDS
			Swollen or painful joints				Stomach / intestinal problems				Recent gain / loss of weight
			Frequent headaches				Gallbladder or gallstones				Arthritis / bursitis
			Dizziness or fainting				Jaundice or hepatitis				Recurrent back pain
			Ear, nose, throat trouble				Broken bones				Frequent trouble sleeping
			Wear glasses or contacts				Frequent or painful urination				Depression
			Chronic or frequent colds				Kidney stones				Loss of memory / amnesia
			Severe tooth/gum trouble				Sugar or albumin in urine				Nervousness / anxiety
			Sinusitis / Hay fever				Blood in urine				Loss of consciousness
			Head injury				Shortness of breath				Considering more children
			Thyroid Disorders				Chest pain or pressure				Change in menstrual cycle
			Asthma				Heart Palpitations				Ovarian cysts
			Chronic cough				Heart trouble				Allergic to grapeseed, sesame seed, cottonseed oil
			High/low blood pressure				Cancer				

Other medical conditions that you have been diagnosed with:

1.

2.

3.

4.

Surgical History:

1. Date: ___ / ___ / ___

2. Date: ___ / ___ / ___

3. Date: ___ / ___ / ___

Family History

(Immediate family only, parents and siblings)

Do you have any family members with Osteoporosis? ☐ **YES** ☐ **NO** If **YES**, list each family member:
Have any women in your family had Cancer? ☐ **YES** ☐ **NO** **Breast** □ **Uterine** □ **Ovarian** □ **Cervical** □ **Other** □ If **YES**, list each family member, including type and date:
Do you have any family members with diabetes? ☐ **YES** ☐ **NO** If **YES**, list each:
Do you have any family members with cardiovascular disease? ☐ **YES** ☐ **NO** If **YES**, list each:
Do you have any family members with blood clots? ☐ **YES** ☐ **NO** If **YES**, list each:

Review of Hormone Symptoms

Rate the following symptoms:

- Fill each field with a number **between 0 and 10**
- 0 = **None** 10 = **Severe**

Difficulty Falling Asleep	Water Retention	Cold Hands or Feet
Insomnia	Acne and/or oily Skin	Breast Tenderness
Irritability	Dry skin	Vaginal Dryness
Mood Swings	Dry hair or hair loss	PMS 7–10 Days Before Period
Difficulty Concentrating	Headaches	Heavy Periods
Urinary Leakage	Abnormal Hair Growth	Difficulty Achieving Orgasm

Other Symptoms:

Please answer the following questions so that your Provider is better able to understand your symptoms: **1** = I feel terrible **10** = I feel awesome

Energy 30 min after you wake up

1 2 3 4 5 6 7 8 9 10

Energy in the afternoon

1 2 3 4 5 6 7 8 9 10

Libido

1 2 3 4 5 6 7 8 9 10

Stress level (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Anxiety (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Memory (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Pain (1 = Low, 10 = High)

1 2 3 4 5 6 7 8 9 10

Any acid reflux / bloating symptoms? ☐ **YES** ☐ **NO**

Weight – happy / not happy? ☐ **YES** ☐ **NO** (If **NO**, how much would you like to lose?)

Loss of Strength / Muscle Mass - despite regular exercise? ☐ **YES** ☐ **NO**

Hot flashes / Night Sweats? ☐ **YES** ☐ **NO**

Number of bowel movements a day? ___________

Hours of uninterrupted sleep nightly? ___________

Patient Signature: ____ **Date:** ______________

Rejuve
HEALTH CLINICS

ACKNOWLEDGEMENT RECEIPT: HIPAA NOTICE OF PRIVACY PRACTICES

In signing this form, you agree that you have received our **Notice of Privacy Practices**. This Notice, among other points, explains how we plan to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. This applies to the privacy practices of **Rejuve Health Clinics Inc**. You have the right to review our **Notice of Privacy Practices** prior to signing this form. It provides more detail on how we may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested by asking our front desk.

By signing this form, you acknowledge you have received our Notice of Privacy Practices and that **Rejuve Health Clinics Inc.** can use and disclose your protected health information in accordance with HIPAA.

Signature of individual or surrogate decision maker:

_______________________________ _____________________________ _____________

FULL NAME SIGNATURE DATE

Relationship to resident/patient/legal authority (if applicable)

________________________________ ___________________________ ____________

FULL NAME RELATIONSHIP DATE