Female New Patient Questionnaire

Patient Demographics

First Name:	Middle:	Last Name:	
Home Phone:		Cell Phone:	
Email:			SSN:
Address:			City:
State:	Zip:	Age:	Date of Birth:
Referred by:		Primary Care Physician:	
OBGYN:		Marital Status:	
Occupation:		Employer:	

Medical Information

Last Menstrual Period:		Number of Pregnancies:
Height:	Weight:	Number of Children:
Blood Pressure: (Office use only)		

Emergency Contact Information

Name:	Relationship:
Primary Phone:	Secondary Phone:
Email:	

Reason for Visit:

Restoration Medicine
700 Montgomery Hwy, Ste 210
Vestavia Hills, AL 35216

www.avcrestorationmedicine.com
Phone: (205) 823-0151
Fax: (205) 823-5218

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Allergies (List all allergies - Food, Drug, Other)

Current Medications (List all current medications)

Drug	Dose	How Often?

Supplements (List all current supplements)

Supplement	Dose	How Often?

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Symptoms of Hormonal Deficiencies (check all that apply)

	Decreased or absent sex drive (libido)
	Fatigue and lack of energy
	Infrequent or absent orgasms
	Change in mood, anxiety and/or depression
	Insomnia
	Declining mental ability and memory
	Feeling of hopelessness and no motivation
	New migraine headaches
	Diminished strength and exercise tolerance
	Muscle shrinkage
	Joint aches and/or new onset of arthritic symptoms
	Dry eyes
	Poor balance and coordination
	Weight gain
	New or increased cellulite
	Ringing in the ears
	Hot flashes and night sweats
	Dry vagina or painful intercourse

	Dry and wrinkled skin
	Height has decreased, osteoporosis or osteopenia
	Bladder spasms
	Bladder infections
	PMS
	Felt better when I was pregnant
	Cold all the time
	Swelling all over the body
	Constipation
	Hair falling out or breaking off
	Brittle nails
	Stay up for over 24 hours
	Difficulty taking oral birth control pills
	Other:

Birth Control Method (Check all that apply). You must be in menopause, have had a hysterectomy, or use birth control to use pellet therapy

	Menopause
	Hysterectomy
	Tubal ligation
	Birth control pills
	Abstinence
	Vasectomy

	Mirena IUD
	Other IUD
	Other:

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Past Surgeries (List year of surgery)

Year	Surgery
	Lap Band Surgery or Obesity Surgery
	Hysterectomy
	Open Heart Surgery
	Joint Replacement
	Cancer Surgery
	Pacemaker
	Removal of ovaries

Habits (Check all that apply)

	Smoking Cigarettes Or Cigars
	I Drink More Than 10 Drinks of Alcohol/Week
	I am a Recovering Alcoholic
	I Use or Have Used Marijuana In Past Year
	I Use or Have Used Cocaine
	I Use or Have Used Heroin

Medical History (Check all that apply)

	Hepatitis or HIV (List Type)
	Breast cancer
	Uterine cancer
	Colon cancer
	Ovarian cancer
	Other cancer
	Blood clot or clotting disorder
	Heart attack
	Stroke
	Vascular disease
	High blood pressure
	High cholesterol
	Heart arrhythmia
	Emphysema (COPD
	TB (Tuberculosis)
	Glaucoma
	ADD, ADHD
	Depression/Anxiety
	Manic depression (bipolar) or mania
	Schizophrenia
	Leber's Optic Neuritis

	Psychological/psychiatric illness
	Restless leg
	Sleep apnea
	Narcolepsy
	Arthritis
	Rheumatoid arthritis
	Osteopenia or osteoporosis
	Fibro myalgia
	Lupus or autoimmune disease
	Chronic disease
	Chronic fatigue
	Adrenal fatigue
	Multiple sclerosis
	Diabetes type I
	Diabetes type II
	Hypoglycemia
	Insulin Resistance
	Thyroid disease Hypo Hyper
	Addisons disease or Cushings disease
	Kidney disease
	Other

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Exercise History (Check all that apply)

	I don't exercise
	I have a very physical job so I don't exercise in addition
	I exercise every day for _____ minutes
	I exercise more than three times a week for over 50 minutes
	Normal daily activity is what I consider exercise
	I am a long distance runner
	I lift weights times a week
	Other:

Diet (Check all that apply)

	I eat anything I want
	I don't eat much but gain weight anyway
	I have gained weight in my belly since I turned 40
	I eat a balanced diet, 3 times a day
	I eat 6 small meals a day
	I don't eat wheat (gluten intolerance)
	I limit carbohydrates
	I eat a low fat diet
	Atkins/South Beach Diet
	Vegan/Vegetarian
	Special diet or restrictions
	Other:

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Preventative Medical Care (Check all that apply)

	Medical/GYN exam in the last year
	Mammogram in last 12 months
	Bone density in last 12 months (if over 50)
	Pelvic ultrasound in last 12 months (If you have a uterus)

Hormone Replacement I have used (Check all that apply)

	Oral pills synthetic (Ogen, Premarin, Estrace, etc.)
	Patch
	Vaginal ring
	Other

Bioidentical Hormone replacement I have used (Check all that apply)

	Pills
	Pellets
	Creams/gels applied on the skin or in the vagina
	Sublingual or buccal tablets (dissolve in the mouth)

Family History (Check all that apply)

	Heart Disease
	Breast Cancer
	Uterine cancer
	Stroke
	Arrhythmia
	Diabetes

	Alzheimer's / Dementia any type
	Blood clots
	Rheumatoid arthritis/Lupus
	Thyroid disease — high or low
	Osteoporosis
	Hemochromatosis

I attest that all the information I give is true.

Print Name: Signature: Date:

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Communication

Consent to Communicate

Please indicate the ways you consent for Restoration Medicine to communicate with you

	Can contact (Yes/No)	Can leave message (Yes/No)
Cell Phone		
Home Phone		
Work Phone		
Email		
Text Message		

Do we have permission to speak with spouse/partner? Yes_____ No_____

Do we have permission to leave a message with spouse/partner? Yes_____ No_____

If yes, please list name(s) and relationship _____

Print Name:_____ Signature:_____ Date:_____

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