Optima
Medical Hormone Replacement
& Aesthetic Center

Female Patient Questionnaire & History

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Occupation: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____ May we contact you via E-Mail? ( ) **YES** ( ) **NO**

In Case of Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ How did you find us: _____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

In the event we cannot contact you by the means you've 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.

Contact Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Habits:

( ) I smoke cigarettes or cigars _____ per day.
( ) I drink alcoholic beverages _____ per week.
( ) I use caffeine _____ a day.
( ) I do cardio exercise _____ times a week.
( ) I do weight training _____ times a week.

Medicare:

Are you enrolled in Medicare __yes ___no

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Medical History

Any known drug allergies: _____

Have you ever had any issues with local anesthesia (lidocaine or epinephrine)? ( ) Yes ( ) No
If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

( ) Medical/GYN Exam Date: _____
( ) Mammogram Date: _____
( ) Bone Density Test Date: _____

Past Medical/Surgical History:

Pregnancies: _____ Live Children: _____

( ) Breast Cancer.
( ) Uterine Cancer.
( ) Ovarian Cancer.
( ) Hysterectomy with removal of ovaries.
( ) Hysterectomy only.
( ) Oophorectomy Removal of Ovaries.

Birth Control Method:

( ) Menopause.
( ) Hysterectomy.
( ) Tubal Ligation.
( ) Birth Control Pills.
( ) Vasectomy.
( ) Other: _____

Medical Illnesses:

( ) High blood pressure
( ) High cholesterol
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot/pulmonary emboli/clotting disorder
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Fibromyalgia/Chronic Fatigue
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Kidney Disease
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Osteopenia
( ) Osteoporosis
( ) Cancer (type): _____
Year: _____