Vivacity Clinic of Las Vegas

FEMALE PROFILE SHEET

Name: _____ Date: _____

Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Cell/Phone #: _____ Work #: _____

Email: _____ Age: _____ DOB: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relation:_____ Phone:_____

MEDICAL QUESTIONNAIRE

(Please circle YES or NO)

Medical History: _____ **No Medical Conditions**

Diabetes	Yes No	High Cholesterol	Yes No
High Blood Pressure	Yes No	Osteoporosis	Yes No
Heart Attack	Yes No	Blood Clots	Yes No
Heart Disease	Yes No	Stroke	Yes No
Multiple Sclerosis	Yes No	Asthma/COPD	Yes No
Epilepsy/Seizure	Yes No	Liver Disease	Yes No
Urinary Tract Infections	Yes No	Kidney Disease	Yes No
Bowel Problems	Yes No	Uterine Fibroids	Yes No
Abnormal Bleeding	Yes No	Polycystic Ovaries	Yes No
Sexually Transmitted	Yes No	Insomnia	Yes No
Thyroid Problems	Yes No	Major Depression	Yes No

Other: _____

Previous Major Surgery: _____ **No Major Surgeries**

Heart	Yes No	Cesarean Section	Yes No
Hysterectomy/Ovaries	Yes No	Appendix Removal	Yes No
Gallbladder Removal	Yes No	Thyroid	Yes No
Tubal Ligation	Yes No	Breast Augmentation	Yes No
Joint Replacement	Yes No	Back Surgery	Yes No
Bowel Surgery	Yes No	Gastric Bypass	Yes No

Other: _____

Patient's Initials: _____

Vivacity Clinic of Las Vegas

Women's Health History: _____ **Date/Year Last Menstrual Period**

Total number of pregnancies: _____		Birth Control/Methods: _____	
Menopause	Yes No	Regular Cycles	Yes No
Painful Periods	Yes No	Flow more than 7 days	Yes No
Use more than 3 pads	Yes No	Cycles affect quality of life	Yes No
Sexually active	Yes No	Sexual issues	Yes No

Family History: *(Parents, Siblings, Children)* _____ **Unremarkable**

Diabetes	Yes No	Heart Attack	Yes No
Cancer	Yes No	High Blood Pressure	Yes No
Osteoporosis	Yes No	Stroke	Yes No
Blood Clots	Yes No	High Cholesterol	Yes No
Thyroid Disease	Yes No	Suicide/Mental Illness	Yes No

Others: _____

Lifestyle Information: (circle your answers)

Alcohol (wine/beer)	Yes	No	*Specify number of drinks per day:* _____
Alcohol (hard liquor)	Yes	No	*Specify number of drinks per day:* _____
Cigarettes:	Yes	No	*Specify how many:* _____ *How Long:* _____
Cigars:	Yes	No	*Specify how many:* _____ *How Long:* _____
Chewing Tobacco:	Yes	No	*Specify how often per day:* _____
Recreational Drugs:	Yes	No	*Specify:* _____
Caffeine (cola, tea)	Yes	No	*Specify number of drinks per day:* _____
Physical Activity:	Yes	No	*Specify: ____Inactive ____Light ____ Moderate ____ Heavy(exercises daily)*
Stress Management	Yes	No	*Specify: what type:* _____ *How Long:* _____
Marital Status:	Check one		*____Single ____Married ____ Casual Partner ____Divorced ____Separated*
Exercise Habits:	Per Week		*5-7 days 3-4 days 1-2days None*

Allergies: P*lease specify and note type of reaction:*

Drug Allergies?	Yes	No	*Specify:* _____
Seasonal Allergies?	Yes	No	*Specify:* _____
Food Allergies?	Yes	No	*Specify:* _____

Patient's Initials: _____

Nutritional/Natural Supplements: *Please list products you use occasionally or regularly and doses:*

Vitamins: Multivitamin, B, C, D, E _____
Minerals: calcium, magnesium, zinc, copper _____
Herbs: Ginseng, Ginkgo Biloba, Echinacea, Ginger, other _____
Enzymes (digestive formulas, CoQ10) other_____
Nutrition/protein supplements (protein powders, amino acids, fish oils) other_____
Others: glucosamine, resveratrol, aloe vera, etc_____

Diet: *Describe your typical daily food intake*:

Breakfast:_____ # of servings: _____

Lunch:_____ # of servings: _____

Dinner:_____ # of servings: _____

Other/Snacks:_____ # of servings: _____

Are most of your meals _____ at home _____ at restaurants

About how many calories you eat each day? _____

Are you currently dieting or using diet pills?**Yes No** Specify _____

Weight in high school _____ Goal weight _____

Tests & Health Screening: *Have you had any of the following tests performed? Check those that apply, note* ***month/year of last test***:

Mammogram	**No Yes**	Mo/Year_____	Results_____
PAP	**No Yes**	Mo/Year____	Results_____
Pelvic Exam	**No Yes**	Mo/Year_____	Results_____
Physical Exam	**No Yes**	Mo/Year_____	Results_____
Colonoscopy	**No Yes**	Mo/Year_____	Results_____
DEXA/Bone scan	**No Yes**	Mo/Year_____	Results_____
Blood Sugar	**No Yes**	Mo/Year_____	Results_____
Cholesterol	**No Yes**	Mo/Year_____	Results_____
Thyroid	**No Yes**	Mo/Year_____	Results_____
Hormone tests	**No Yes**	Mo/Year_____	Results_____
Other labs	**No Yes**	Mo/Year_____	Results_____

Patient's Initials: _____

Symptoms: Please **rate** the following symptoms:

	0 = None/Rare	**1= Mild**	**2 = Moderate**	**3 = Serious**
Difficulty Concentrating				
Vaginal Dryness				
Cold all the time				
Difficulty Sleeping				
Night Sweats				
Hair loss				
Body aches				
Migraines/Headaches				
Bloating				
Moodiness				
Hot Flashes				
Urinary Tract Infections				
Weight Gain				
Fatigue				
Foggy Thinking				
Tender Breasts				
Sugar/Salt/Caffeine Cravings				
Increased Facial Hair				
Dry Hair or Skin				
Less than 3 bowel movement/week				
Decreased Libido				

Are you currently seeing a Primary Care Physician? **Yes** **No** *(if yes provide name and contact info.)*

_____

Current medications: *Name & Dosage & Prescribing Physician* **___No current medications**

_____

_____

_____

Patient's Initials: _____

Health Concern in order of importance

Primary Problem: _____

Secondary Problem: _____

Tertiary Problem: _____

Health Goals

Primary Goal: _____

Secondary Goal: _____

Tertiary Goal: _____

How did you hear about Vivacity Clinic of Las Vegas?

Newspaper: ____ Publication: ____ (Which one?) _____

Television: ____ Radio: ____ Website: ____ (Provide Source :) _____

Friend/Relative: ____ (Name of friend) _____

Other: _____

Would You Like Additional Information Regarding Our Services/Products?

Weight-Loss? _____ Bio-Identical Hormones? _____ Cosmetics? _____ Anti-Aging?_____

Intravenous Therapy? _____ Supplements? _____ Hormone Optimization? _____ Others: _____

I certify that this health history given is correct and accurate. I understand that I must provide current copies of health tests and records prior to being prescribed hormone therapy. I understand that **it is my responsibility to update my provider of any changes in my medical history.**

Patient's Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____

Patient's Initials: _____