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**REPRODUCTIVE ENDOCRINOLOGY**

**BREYER MEDSPA**

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REPRODUCTIVE ENDOCRINOLOGY      INFERTILITY      PELVIC PAIN      POLY-CYSTIC OVARY SYNDROME

**HAVE YOU CHANGED YOUR INSURANCE? NO YES    WILL YOUR INSURANCE CHANGE IN THE NEAR FUTURE? NO YES**

**IF YES, PLEASE MAKE SURE WE HAVE COPIES OF YOUR CARDS.**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ DATE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ OCCUPATION \_\_\_\_\_ RELIGION \_\_\_\_\_

IS THIS YOUR 1<sup>ST</sup> MARRIAGE? \_\_\_\_\_ 2<sup>ND</sup> \_\_\_\_\_ PARTNER'S 1<sup>ST</sup> \_\_\_\_\_ 2<sup>ND</sup> \_\_\_\_\_

**MAIN REASONS FOR SEEKING HELP:** INFERTILITY \_\_\_\_\_ PELVIC PAIN \_\_\_\_\_

ENDOMETRIOSIS \_\_\_\_\_ IRREGULAR/ABNORMAL BLEEDING \_\_\_\_\_ EXCESS HAIR \_\_\_\_\_

ACNE \_\_\_\_\_ MENOPAUSE \_\_\_\_\_ FIBROID TUMORS \_\_\_\_\_ OSTEOPOROSIS \_\_\_\_\_

IN-VITRO FERTILIZATION \_\_\_\_\_ TUBAL LIGATION REVERSAL \_\_\_\_\_ PCOS \_\_\_\_\_

HAIR LOSS \_\_\_\_\_ ROUTINE GYN \_\_\_\_\_ OTHER \_\_\_\_\_

**GYN HISTORY:**

AGE OF FIRST PERIOD \_\_\_\_\_ TEENAGE PERIODS: REGULAR  IRREGULAR

IF IRREGULAR, HOW OFTEN \_\_\_\_\_ LENGTH OF FLOW \_\_\_\_\_

IF IRREGULAR AT FIRST AND THEN REGULAR, AT WHAT AGE DID THEY BECOME REGULAR? \_\_\_\_\_

REGULAR ON THEIR OWN OR BECAUSE OF BIRTH CONTROL PILLS? \_\_\_\_\_

**PERIODS NOW:** HOW OFTEN DO THEY OCCUR? \_\_\_\_\_

LENGTH OF FLOW \_\_\_\_\_ AMOUNT OF FLOW \_\_\_\_\_ HOW MANY PERIODS A YEAR \_\_\_\_\_

SPOT OR STAIN: BEFORE PERIOD?  AFTER?  IN-BETWEEN?

RECENT CHANGE IN PERIODS? NO  YES  HOW \_\_\_\_\_

LONGEST TIME WITHOUT PERIOD (NOT PREGNANT) \_\_\_\_\_

**WHEN WAS YOUR LAST MENSTRUAL PERIOD?** \_\_\_\_\_ **NORMAL?** YES  NO

IF NOT NORMAL, HOW? \_\_\_\_\_

LOWER ABDOMINAL PAIN/LOW BACK PAIN/CRAMPS WITH PERIOD? YES  NO  N/A

WHEN DID THIS PAIN FIRST OCCUR ? \_\_\_\_\_ DID ANYTHING TRIGGER IT? \_\_\_\_\_

HOW BAD ON A SCALE OF 1-10: LESS 1 2 3 4 5 6 7 8 9 10 MORE

IS PAIN GETTING WORSE? NO  YES  DOES PAIN BEGIN BEFORE FLOW? NO  YES

HOW LONG BEFORE? 1 DAY  2-4 DAYS  5-7 DAYS  8-10 DAYS  10-14 DAYS  MORE

HOW MANY DAYS OF FLOW DOES PAIN LAST? 1-2  3-4  5-6  ENTIRE FLOW

PAIN PERSISTS AFTER THE FLOW ENDS? NO  YES  HOW MANY DAYS? \_\_\_\_\_

WHERE DO YOU FEEL THE PAIN THE MOST \_\_\_\_\_

WHERE ELSE DO YOU FEEL IT? LOW ABD  LOW BACK  THIGHS  OTHER \_\_\_\_\_

PAIN IN THE RECTUM?  VAGINA?

DID YOU HAVE PAIN AS A TEENAGER?  IF SO, BAD AS NOW  BETTER  WORSE

WHAT HAS BEEN THE PATTERN TO THE PAIN OVER THE YEARS? \_\_\_\_\_

\_\_\_\_\_

PAIN DURING SEX? NOT SEXUALLY ACTIVE

NO  YES

SEX IS ALWAYS PAINFUL  1 2 3 4 5 6 7 8 9 10

USUALLY PAINFUL  1 2 3 4 5 6 7 8 9 10

OCCASIONALLY PAINFUL  1 2 3 4 5 6 7 8 9 10

PAIN ON INITIAL ENTRY  1 2 3 4 5 6 7 8 9 10

PAIN ON FULL PENETRATION  1 2 3 4 5 6 7 8 9 10

PAIN VARIES WITH TIME OF THE CYCLE  1 2 3 4 5 6 7 8 9 10

DOES PAIN VARY WITH POSITION  1 2 3 4 5 6 7 8 9 10

WOULD BE PAINFUL BUT I HAVE LEARNED HOW TO AVOID THE PAIN  1 2 3 4 5 6 7 8 9 10

IF PAINFUL, WHERE DO YOU FEEL THE PAIN \_\_\_\_\_

PAIN FELT DURING SEX  AFTERWARDS  BOTH

IF PAIN PERSISTS AFTER, HOW LONG \_\_\_\_\_

WHAT POSITIONS ARE MORE PAINFUL \_\_\_\_\_

WHAT POSITIONS ARE LESS PAINFUL \_\_\_\_\_

NAME \_\_\_\_\_

**LOWER ABDOMINAL, PELVIC PAIN, OR LOW BACK PAIN BETWEEN PERIODS ?** NO  YES

HOW BAD? LESS 1 2 3 4 5 6 7 8 9 10 MORE

CONSTANTLY  EVERY DAY  FREQUENTLY  OCCASIONALLY  AT OVULATION

MAIN LOCATION \_\_\_\_\_ OTHER LOCATIONS \_\_\_\_\_

PAIN IS: SHARP  DULL  STEADY  PRESSURE  BURNING

CRAMPY  CONSTANT  INTERMITTENT

ANY PATTERN TO THE PAIN \_\_\_\_\_

PAIN BETWEEN PERIODS THE SAME AS WITH YOUR PERIODS? NO  YES

OR DIFFERENT NO  YES  HOW? \_\_\_\_\_

IF DIFFERENT, WHEN DID THIS PAIN BEGIN? \_\_\_\_\_

PAIN "RADIATES" TO OTHER LOCATIONS?  WHERE \_\_\_\_\_

WHAT MAKES PAIN WORSE \_\_\_\_\_

WHAT MAKES PAIN BETTER \_\_\_\_\_

DESCRIBE THE PAIN \_\_\_\_\_

WHAT TIME OF DAY IS PAIN WORSE? \_\_\_\_\_ BETTER? \_\_\_\_\_

WHAT EFFECT DO THE FOLLOWING HAVE ON THE PAIN? URINATION: BETTER  WORSE  NO DIFF

BOWEL MOVEMENTS: BETTER  WORSE  NO DIFF  SEX: BETTER  WORSE  NO DIFF

PHYSICAL ACTIVITY: BETTER  WORSE  NO DIFF  TAMPON USE: BETTER  WORSE  NO

DIFF

WHAT HAVE YOU BEEN TOLD IS THE CAUSE OF YOUR PAIN \_\_\_\_\_

WHAT DO YOU THINK IS THE CAUSE \_\_\_\_\_

LIST ALL TREATMENTS YOU HAVE UNDERGONE FOR YOUR PAIN \_\_\_\_\_

IF YOU TOOK BIRTH CONTROL PILLS WHILE YOU WERE HAVING PAIN, DID THE "PILL" MAKE THE PAIN DISAPPEAR?

\_\_\_\_\_ BETTER? \_\_\_\_\_ WORSE? \_\_\_\_\_ NO CHANGE? \_\_\_\_\_

PELVIC SYMPTOMS CAUSE YOU TO MISS TIME FROM WORK, SCHOOL, SOCIAL EVENTS? NO  YES

HOW MUCH TIME \_\_\_\_\_

**PREGNANCY HISTORY:**

HOW MANY TIMES HAVE YOU BEEN PREGNANT? \_\_\_\_\_ LAST PREGNANCY \_\_\_\_\_

HOW MANY CHILDREN HAVE YOU DELIVERED \_\_\_\_\_ VAGINAL \_\_\_\_\_ CESAREAN \_\_\_\_\_

HOW MANY MISCARRIAGES \_\_\_\_\_ HOW MANY ELECTIVE ABORTIONS \_\_\_\_\_

COMPLICATIONS FROM ANY PREGNANCY  DESCRIBE \_\_\_\_\_

WERE FORCEPS OR A VACUUM EXTRACTOR USED DURING ANY OF YOUR DELIVERIES? NO  YES

ANY BABIES WHO WEIGHED MORE THAN 9 LBS? YES  NO

HOW LONG TO CONCEIVE \_\_\_\_\_ EVER UNDERGO INFERTILITY THERAPY NO  YES

IF YES, DESCRIBE \_\_\_\_\_

I NEVER TRIED TO BECOME PREGNANT IN ANY RELATIONSHIP

**LIST ALL DRUG ALLERGIES:**

DRUG	TYPE OF REACTION
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**LIST ALL CURRENT PRESCRIPTION DRUGS (AND DOSE):**

**LIST ALL OVER-THE-COUNTER DRUGS YOU TAKE FREQUENTLY (INCLUDING VITAMINS): IF VITAMINS - NORMAL DOSES OR "MEGA" DOSES?**

**LIST ANY "HERBAL" DRUGS OR SIMILAR MEDICATIONS YOU TAKE**

NAME \_\_\_\_\_

**IF PAIN IS A MAJOR REASON FOR COMING TO SEE ME, PLEASE CHECK ALL PAIN MEDS YOU HAVE TAKEN IN THE PAST AND HOW WELL THEY WORKED OR DID NOT WORK.**

- | <b>DRUG</b>                                       | <b>WORKED WELL</b> | <b>SO-SO</b> | <b>DID NOT WORK</b> | <b>MANY SIDE EFFECTS</b> |
|---|--------------------|--------------|---------------------|--------------------------|
| <input type="checkbox"/> MOTRIN, ETC *            |                    |              |                     |                          |
| <input type="checkbox"/> TYLENOL / CODEINE        |                    |              |                     |                          |
| <input type="checkbox"/> VICODIN / LORCET / NORCO |                    |              |                     |                          |
| <input type="checkbox"/> PERCODAN / PERCOCET      |                    |              |                     |                          |
| <input type="checkbox"/> OXYCONTIN / OXY IR       |                    |              |                     |                          |
| <input type="checkbox"/> DURAGESIC                |                    |              |                     |                          |
| <input type="checkbox"/> MSCONTIN                 |                    |              |                     |                          |
| <input type="checkbox"/> AVINZA                   |                    |              |                     |                          |
| <input type="checkbox"/> STADOL                   |                    |              |                     |                          |
| <input type="checkbox"/> DEMEROL                  |                    |              |                     |                          |
| <input type="checkbox"/> ELAVIL                   |                    |              |                     |                          |
| <input type="checkbox"/> NEURONTIN                |                    |              |                     |                          |
| <input type="checkbox"/> ELMIRON                  |                    |              |                     |                          |

OTHER \_\_\_\_\_

OTHER \_\_\_\_\_

\* - ADVIL, NUPRIN, ALEVE, NAPROSYN, ANAPROX, MOBIC, CELEBREX, PONSTEL, ETC.

**DES:**

DID YOUR MOTHER TAKE "DES" WHEN PREGNANT WITH YOU? NO  YES

(THIS IS POSSIBLE IF YOU WERE BORN BETWEEN 1948 AND 1970)

WRE YOU EVER GIVEN "DES" WHEN PREGNANT? YES  NO

**CONTRACEPTION HISTORY:**

BIRTH CONTROL PILLS:  HOW LONG \_\_\_\_\_ LAST TAKEN \_\_\_\_\_

IUD(COIL):  HOW LONG \_\_\_\_\_ REMOVED \_\_\_\_\_ WHY \_\_\_\_\_

ANY PROBLEMS WITH IUD \_\_\_\_\_

CURRENT METHOD OF CONTRACEPTION: CONDOM \_\_\_\_\_ CREAMS/FOAM \_\_\_\_\_ SPONGE \_\_\_\_\_ SUPPOSITORIES \_\_\_\_\_

RHYTHM \_\_\_\_\_ DIAPHRAGM \_\_\_\_\_ WITHDRAWAL \_\_\_\_\_ DOUCHING \_\_\_\_\_

TUBAL / VASECTOMY \_\_\_\_\_ **HAVE NEVER USED CONTRACEPTION** \_\_\_\_\_

**SEXUAL HISTORY:**

AGE WHEN YOU FIRST HAD SEX \_\_\_\_\_

NUMBER OF SEX PARTNERS (EVER): 1  2  3-5  6-10  OVER 10

AVERAGE FREQUENCY OF SEX EACH WEEK \_\_\_\_\_ SEX DRIVE: GOOD  OK  POOR

IS SEX SATISFACTORY FOR YOU \_\_\_\_\_ IF NOT, WHY? NO DESIRE  UNABLE TO RESPOND

TOO PAINFUL  UNABLE TO REACH ORGASM  OTHER \_\_\_\_\_

USE ARTIFICIAL LUBRICANTS WITH SEX? NO  YES

IF YES, WHAT DO YOU USE? \_\_\_\_\_

BLEED AFTER SEX?  DOUCHE AFTER SEX?

EVER BEEN TOUCHED AGAINST YOUR WILL AS A CHILD? NO  YES

EVER RAPED, ABUSED, A BATTERED CHILD, WIFE OR GIRL-FRIEND? NO  YES

IF YES, HOW OLD WERE YOU WHEN THE ABUSE OCCURRED? \_\_\_\_\_

WAS THE ABUSE SEXUAL, PHYSICAL, OR EMOTIONAL? \_\_\_\_\_

HOW LONG DID IT GO ON? \_\_\_\_\_

DO YOU STILL THINK ABOUT IT? NO  YES  IF YES, HOW OFTEN? \_\_\_\_\_

HAVE YOU DEALT THE ABUSE? \_\_\_\_\_ HOW \_\_\_\_\_

DO YOU FEEL COMFORTABLE IN YOUR CURRENT RELATIONSHIP? YES  NO

IF NOT, WHY \_\_\_\_\_

NAME \_\_\_\_\_

EVER HAVE AN ABNORMAL PAP SMEAR? YES  NO  HAD A COLPOSCOPY YES  NO

WHAT WERE THE COLPOSCOPY RESULTS \_\_\_\_\_

HAS YOUR CERVIX EVER BEEN TREATED IN ANY WAY?  IF SO ,HOW? HOT CAUTERY

CONE BIOPSY  CRYO (FREEZING)  LASER  LEEP  LOOP  LLETZ

LAST MAMMOGRAM \_\_\_\_\_ RESULT \_\_\_\_\_

LAST PAP SMEAR \_\_\_\_\_ RESULT \_\_\_\_\_

**PMS:**

DO YOU HAVE PMS? NO  YES  HOW BAD? LESS 1 2 3 4 5 6 7 8 9 10 MORE

WHAT ARE YOUR MAIN SYMPTOMS? \_\_\_\_\_

**IF POST-MENOPAUSAL:**

AT WHAT AGE? \_\_\_\_\_ NATURAL  HYSTERECTOMY

ARE YOU HAVING HOT FLASHES?  NIGHT SWEATS?  MOOD SWINGS?

VAGINAL DRYNESS?  PAINFUL INTERCOURSE?  LOSS OF SEX DRIVE?

URINARY FREQUENCY?  URGENCY?  BURNING?

URINARY INCONTINENCE?  IF SO, DESCRIBE \_\_\_\_\_

WERE YOU EVER GIVEN ESTROGEN IN THE PAST? YES  NO  TAKING ESTROGEN NOW?

IF YOU TOOK ESTROGEN AND HAVE STOPPED, WHY? \_\_\_\_\_

HAVE YOU HAD ANY BLEEDING SINCE MENOPAUSE?  IF YES, DESCRIBE \_\_\_\_\_

MOTHER'S AGE OF MENOPAUSE \_\_\_\_\_ NATURAL  SURGICAL

FAMILY HISTORY OF EARLY MENOPAUSE (UNDER AGE 40) NO  YES  WHO \_\_\_\_\_

**PERSONAL HISTORY - CHECK OFF ( )** THOSE YOU HAVE, HAVE HAD, OR WERE TOLD YOU HAVE:

- USUAL CHILDHOOD ILLNESSES  ASTHMA  RHEUMATIC FEVER  HEART DISEASE   
STROKE  CONCUSSION  MIGRAINES  ARTHRITIS  HEPATITIS "A"   
HEPATITIS "B"  HEPATITIS "C"  MONONUCLEOSIS  POLIO  ULCER  NEPHRITIS   
KIDNEY INFECTION  GONORRHEA  SYPHILIS  JAUNDICE  ANEMIA  TB   
DIABETES  HIGH BLOOD PRESSURE  NERVOUS BREAKDOWN  EPILEPSY   
ULCERATIVE COLITIS  KIDNEY STONE  PHLEBITIS  NEURITIS  HYPOGLYCEMIA   
THYROID DISEASE  HEART ATTACK  CHLAMYDIA  PID  HIV   
INFECTION IN TUBES / OVARIES  AIDS  GLAUCOMA  HERPES  FIBROID TUMORS   
CANCER  WHERE \_\_\_\_\_ CHEMOTHERAPY  HIGH CHOLESTEROL   
MITRAL VALVE PROLAPSE  ABNORMAL PAP SMEAR  HPV   
CHRONIC FATIGUE SYNDROME  LOW BLOOD SUGAR  FIBROMYALGIA   
EPSTEIN-BARR VIRUS SYNDROME  CHRONIC YEAST SYNDROME  INTERSTITIAL CYSTITIS   
URETHRAL SYNDROME  IRRITABLE BOWEL SYNDROME  PELVIC CONGESTION SYNDROME   
FREQUENT BLADDER PROBLEMS OR INFECTIONS AS A CHILD   
DIABETES WHEN PREGNANT  SLEEP APNEA  USE C-PAP MACHINE? YES  NO   
OTHER \_\_\_\_\_  
UNDER ANOTHER PHYSICIAN'S CARE FOR ANY REASON? NO  YES   
WHO AND WHY? \_\_\_\_\_

BLOOD TRANSFUSION?  WHEN \_\_\_\_\_ WHY \_\_\_\_\_

**THYROID DISEASE** YES  NO  IF YES, HOW DIAGNOSED \_\_\_\_\_

UNDERACTIVE  OVERACTIVE  THYROID CANCER  THYROID NODULE

TAKING THYROID HORMONE NOW  WHAT DOSE (OR COLOR TABLET) \_\_\_\_\_

NAME \_\_\_\_\_

**SURGERY:** INDICATE THOSE YOU HAVE HAD **AND** THE **YEAR** (IF YOU REMEMBER)

D&C  \_\_\_\_\_ HYSTEROSCOPY  WHY \_\_\_\_\_

LAPAROSCOPY  WHY \_\_\_\_\_

HYSTERECTOMY  WHY \_\_\_\_\_

MYOMECTOMY  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

ENDOMETRIOSIS  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

PELVIC ADHESIONS  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

OVARIAN CYST  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

TUBAL PREGNANCY  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

GALL BLADDER  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

APPENDECTOMY  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

HERNIA  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

TUBAL LIGATION  OPEN SURGERY \_\_\_\_\_ LAPAROSCOPY \_\_\_\_\_

THYROID SURGERY  BREAST BIOPSY  LUMPECTOMY  YEAR \_\_\_\_\_

ABORTION  MASTECTOMY  BREAST IMPLANTS  BREAST REDUCTION

LEEP  CONE BIOPSY  OTHER CERVICAL SURGERY  WHAT \_\_\_\_\_

GASTRIC BY-PASS, LAP BAND, ETC \_\_\_\_\_

BACK SURGERY  OTHER \_\_\_\_\_

SURGICAL COMPLICATIONS \_\_\_\_\_

HAVE YOU BEEN ADVISED TO HAVE SURGERY YOU DID NOT HAVE? NO  YES

IF YES, WHAT \_\_\_\_\_

WHY DID YOU NOT HAVE THE SURGERY? \_\_\_\_\_

IF YOU HAD A HYSTEROSCOPY AND / OR LAPAROSCOPY OR OTHER GYN SURGERY, WHAT WERE YOU TOLD ABOUT THE

OPERATIVE FINDINGS? \_\_\_\_\_

ANY BROKEN BONES NO  YES  IF YES, WHICH ONES \_\_\_\_\_

DO YOU USE "ALTERNATIVE THERAPIES" OR ARE YOU UNDER THE CARE OF AN ALTERNATIVE MEDICINE PRACTITIONER?  
(ACUPUNCTURE, HOMEOPATHY, NATUROPATHY, CHIROPRACTIC, NUTRITIONAL THERAPY, ETC)

NO

YES

IF YES, DESCRIBE \_\_\_\_\_

**GENERAL HEALTH QUESTIONS:**

HOW IS YOUR GENERAL HEALTH POOR 1 2 3 4 5 6 7 8 9 10 EXCELLENT

CHANGES IN YOUR WEIGHT?  GAINED  LOST  HOW MANY LBS \_\_\_\_\_

MOST YOU HAVE EVER WEIGHED (NOT PREGNANT)? \_\_\_\_\_ LEAST \_\_\_\_\_

ANOREXIA, BULEMIA, PURGING, OR RELATED EATING PROBLEMS \_\_\_\_\_

HAVE YOU EVER GONE ON A CRASH DIET \_\_\_\_\_ OFTEN \_\_\_\_\_

HOW MUCH DID YOU LOSE \_\_\_\_\_ OVER HOW LONG A PERIOD OF TIME \_\_\_\_\_

DID YOU EVER SEE A DIET DOCTOR?  HAVE YOU EVER TAKEN DIET PILLS ?

**DO YOU:** FREQUENTLY FEEL NERVOUS  DEPRESSED

HAVE TROUBLE SLEEPING  HAVE TROUBLE FALLING ASLEEP

WAKE UP IN THE MIDDLE OF THE NIGHT  TROUBLE FALLING BACK TO SLEEP

FEEL TIRED WHEN YOU WAKE UP  ARE YOU TIRED ALL THE TIME

TIRE EASILY WITH NORMAL ACTIVITY  TROUBLE CONCENTRATING

MULTIPLE ACHES AND PAINS  SIGNIFICANT MOOD SWINGS  MEMORY LOSS

HOW MANY HOURS OF UNINTERRUPTED SLEEP DO YOU GET EACH NIGHT? \_\_\_\_\_

IF LESS THAN 6 HOURS, WHAT AWAKENS YOU? \_\_\_\_\_

**PLEASE CHECK OFF THOSE SYMPTOMS OR OTHER PROBLEMS THAT OCCUR FREQUENTLY OR ARE SEVERE:**

FATIGUE  WEAKNESS  FEVER  NIGHT SWEATS  BLURRED VISION  DOUBLE VISION

LOSS OF VISION  HEADACHE  MIGRAINES  RINGING IN THE EARS  DIZZINESS  NECK

PAIN  HOARSENESS  DIFFICULTY SWALLOWING  SINUS PROBLEMS  ALLERGIES

COUGH  CHEST PAIN  SHORTNESS OF BREATH  COUGH UP BLOOD  PALPITATIONS

RAPID HEART BEAT  RHEUMATIC FEVER  ANGINA  ASTHMA  ACTIVE NOW?

PHLEBITIS  DEEP  SUPERFICIAL  IF YES, HOW PROVEN \_\_\_\_\_

NAME \_\_\_\_\_

APPETITE CHANGE  NAUSEA  VOMITING  FOOD INTOLERANCE

HEARTBURN  INDIGESTION  BLOAT

ULCER  GALL BLADDER PROBLEMS  IRRITABLE BOWEL SYNDROME

MAJOR CHANGE IN BOWEL HABITS  CHANGE IN STOOL APPEARANCE

HOW MANY BOWEL MOVEMENTS PER DAY? \_\_\_\_\_ HOW MANY PER WEEK? \_\_\_\_\_

CONSTIPATION  DIARRHEA  RECTAL INCONTINENCE

BLOOD IN STOOL  PAINFUL BOWEL MOVEMENTS

GI SYMPTOMS THAT AWAKEN YOU AT NIGHT?  DESCRIBE \_\_\_\_\_

DID YOU SUFFER CHRONIC CONSTIPATION AS A CHILD? NO  YES

SHARP STABBING PAINS IN THE RECTUM?  VAGINA?

ABDOMINAL PAIN RELIEVED BY BOWEL MOVEMENT

INTESTINAL SYMPTOMS THAT CHANGE WITH YOUR MENSTRUAL CYCLE

IF YES, DESCRIBE \_\_\_\_\_

EVER HAVE A SIGMOIDOSCOPY OR COLONOSCOPY? NO  YES  IF YES, WHEN \_\_\_\_\_

BLADDER PROBLEMS NOW ?  WHAT \_\_\_\_\_

HAVE YOU EVER HAD A BLADDER INFECTION?  FREQUENT INFECTIONS  AS A CHILD?

KIDNEY INFECTION  KIDNEY STONE  IF SO, WHAT TYPE \_\_\_\_\_

KIDNEY X-RAY  IF YES, WHAT DID IT SHOW \_\_\_\_\_

BURNING ON URINATION  URINATE FREQUENTLY  HOW MANY TIMES A DAY? \_\_\_\_\_

FREQUENT URGE TO URINATE  IS THERE A LOT TO PASS  A LITTLE

DO YOU CUT BACK ON YOUR FLUID INTAKE TO DECREASE THE NEED TO URINATE? NO  YES

URINARY HESITANCY (DIFFICULTY STARTING OR MAINTAINING STREAM) NO  YES

GET UP AT NIGHT TO URINATE? NO  YES  HOW OFTEN \_\_\_\_\_

URINARY INCONTINENCE (INVOLUNTARY LOSS OF URINE)  OFTEN

UNDER WHAT CIRCUMSTANCES \_\_\_\_\_

HAVE YOU NOTICED BLOOD IN YOUR URINE  OFTEN

BLADDER SYMPTOMS THAT VARY WITH YOUR MENSTRUAL CYCLE NO  YES

DID YOU HAVE A "STRADDLE" INJURY AS A CHILD? NO  YES

DOES YOUR OCCUPATION FORCE YOU TO HOLD YOUR URINE FOR A LONG TIME? NO  YES

DO YOUR HANDS AND/OR FEET SWELLOFTEN  WHEN \_\_\_\_\_

DO YOU TAKE DIURETICS (WATER PILLS)  HOW OFTEN \_\_\_\_\_

BREAST ENLARGEMENT  BY HOW MUCH \_\_\_\_\_ BREAST FULLNESS  PAIN

LUMPS  WHERE \_\_\_\_\_

SYMPTOMS VARY WITH YOUR MENSTRUAL CYCLE NO  YES

ANY LEAKAGE FROM YOUR BREASTS  WHICH SIDE \_\_\_\_\_ WHAT COLOR IS IT \_\_\_\_\_

DOES IT COME OUT ON ITS OWN OR ONLY IF YOU SQUEEZE \_\_\_\_\_

**VAGINAL DISCHARGE?** NO  YES  DESCRIBE: COLOR: \_\_\_\_\_

ODOR: \_\_\_\_\_ CONSISTENCY: \_\_\_\_\_

VISIBLE INFLAMMATION:  ITCH:  BURN:  IRRITATED:

OTHER: \_\_\_\_\_

ANY SELF-MEDICATIONS RECENTLY? NO  YES  WHICH \_\_\_\_\_

DO YOU DOUCHE?  IF YES, HOW OFTEN \_\_\_\_\_

DO YOU USE ANY FEMININE SPRAYS OR SUPPOSITORIES?

DO YOU USE ANY TALCUM, BABY, OR DUSTING POWDERS IN THE VAGINAL AREA?

**BACKACHE:** RARE  OCCASIONAL  FREQUENTLY  CONSTANTLY

WITH PERIOD OR ANYTIME \_\_\_\_\_ ANY BACK SURGERY

ARTHRITIS  TYPE \_\_\_\_\_

SKIN RASHES \_\_\_\_\_

**ACNE**  AGE OF ONSET \_\_\_\_\_ STILL ACTIVE

ANYTIME  MAINLY WITH PERIOD  MAIN LOCATION(S) \_\_\_\_\_

**COARSE OR DARK HAIR?**  AGE OF ONSET \_\_\_\_\_

LOCATIONS OF EXCESS HAIR \_\_\_\_\_

WHAT HAVE YOU DONE TO REMOVE IT \_\_\_\_\_

HAVE YOU HAD ANY TESTS TO DETERMINE IF THERE IS A HORMONAL CAUSE? YES  NO

ANY TREATMENTS BY A PHYSICIAN \_\_\_\_\_

ARE YOU LOSING HAIR OR GOING BALD  WHERE \_\_\_\_\_

DEEPER VOICE  EASY BRUISING  DARK RED STRETCH MARKS

NAME \_\_\_\_\_

**PERSONAL HABITS:**

SMOKE  HOW MUCH \_\_\_\_\_ HOW LONG \_\_\_\_\_ QUIT \_\_\_\_\_

CAFFEINE  AMOUNT/DAY \_\_\_\_\_

USE ALCOHOL  HOW MUCH \_\_\_\_\_

EXERCISE  HOW MUCH \_\_\_\_\_

FREQUENT ANXIETY/DEPRESSION  PSYCHIATRIC COUNSELING \_\_\_\_\_

ARE YOU EXPOSED TO "SECOND-HAND SMOKE"? NO  YES

IF YES, HOW MUCH \_\_\_\_\_

WITH WHOM DO YOU LIVE? \_\_\_\_\_

WHO ELSE LIVES IN YOUR HOME \_\_\_\_\_

ANY SIGNIFICANT FAMILY OR JOB RELATED CONFLICTS \_\_\_\_\_

**IMMEDIATE FAMILY HISTORY:**

FATHER: AGE \_\_\_\_\_ ALIVE  DEAD  IF DEAD, CAUSE \_\_\_\_\_

MOTHER: AGE \_\_\_\_\_ ALIVE  DEAD  IF DEAD, CAUSE \_\_\_\_\_

SISTERS/BROTHERS: AGES \_\_\_\_\_ IF DEAD, AGE AND CAUSE \_\_\_\_\_

CLOSE\* RELATIVES WITH **EARLY** CARDIOVASCULAR DISEASE? (MEN UNDER AGE 55-WOMEN UNDER 65)

\* CLOSE = PARENTS, SISTERS OR BROTHERS

NO  YES  WHO \_\_\_\_\_

RADIATION (X-RAY) **THERAPY** (NOT DIAGNOSTIC) FOR ANY REASON? NO  YES

WHY? \_\_\_\_\_

WHAT PART OF YOUR BODY WAS TREATED? \_\_\_\_\_

CITY OF BIRTH? YOU \_\_\_\_\_ PARENTS? \_\_\_\_\_

WHAT COUNTRY DID YOU ANCESTORS COME FROM? \_\_\_\_\_

**FAMILY HISTORY: (1<sup>ST</sup> DEGREE ONLY – PARENTS, SIBLINGS, CHILDREN EXCEPT BREAST AND/OR OVARIAN CANCER)**

<b>ILLNESS</b>	<b>WHO (<u>and</u> AGE WHEN DIAGNOSED)</b>
DIABETES	
HIGH BLOOD PRESSURE	
GLAUCOMA	
BREAST CANCER	
OVARIAN CANCER	
COLON / RECTAL CANCER	
OTHER CANCERS	
HEART DISEASE / HEART ATTACK	
VASCULAR DISEASE / STROKE	
THYROID DISEASE	
IRREGULAR PERIODS	
ACNE OR HIRSUTISM (FACIAL HAIR)	
OTHER HORMONE PROBLEMS	
ENDOMETRIOSIS	
LUPUS / RHEUMATOID ARTHRITIS	
OTHER AUTO-IMMUNE DISEASES	
MENTAL RETARDATION / MONGOLISM	
BIRTH DEFECTS	
TAY SACHS DISEASE OR GAUCHER'S DISEASE	
SICKLE CELL ANEMIA	
THALASSEMIA	
PKU	
CYSTIC FIBROSIS	
OSTEOPOROSIS	
ALZHEIMER'S	
OTHER	

NAME \_\_\_\_\_

**INFERTILITY:**

IS HAVING A BABY A MAJOR REASON FOR SEEKING HELP?      NO       YES

IF YES - HOW LONG HAVE YOU BEEN ACTIVELY TRYING \_\_\_\_\_

HOW LONG HAVE YOU NOT USED ANY CONTRACEPTION \_\_\_\_\_

IF PREGNANT BEFORE, WERE ANY FATHERED BY YOUR CURRENT PARTNER?      YES       NO

MARRIED BEFORE ?      YES       NO

IF YES, DID YOU TRY TO CONCEIVE PREVIOUSLY      YES       NO

IF YES, DID YOU BECOME PREGNANT (THEN)      YES       NO

HAS YOUR FIRST PARTNER FATHERED ANY CHILDREN      YES       NO

HAS ANY OTHER PHYSICIAN TRIED TO DETERMINE THE CAUSE OF YOUR INFERTILITY      YES       NO

IF YES - WHO \_\_\_\_\_

WHAT WERE YOU TOLD \_\_\_\_\_

HAS YOUR CURRENT PARTNER FATHERED ANY PREGNANCIES THAT HE KNOWS OF?      NO       YES

HAS YOUR PARTNER BEEN TESTED? NO       YES       RESULT \_\_\_\_\_

**INFERTILITY TESTS DONE**

**RESULT**

X-RAY OF UTERUS AND TUBES \_\_\_\_\_

POST-COITAL (INTERCOURSE) TEST \_\_\_\_\_

UTERINE BIOPSY \_\_\_\_\_

HYSTEROSCOPY OR LAPAROSCOPY \_\_\_\_\_

OVARIAN RESERVE TESTING \_\_\_\_\_

**TREATMENT FOR INFERTILITY:**

CLOMIPHENE (CLOMID/SEROPHENE) \_\_\_\_\_

ARTIFICIAL INSEMINATION \_\_\_\_\_

PERGONAL ETC \_\_\_\_\_

PARLODEL \_\_\_\_\_

PREDNISONE / DEXAMETHASONE \_\_\_\_\_

DANOCRINE / DANAZOL \_\_\_\_\_

PROGESTERONE \_\_\_\_\_

GnRH (LUPRON / SYNAREL) \_\_\_\_\_

LASER LAPAROSCOPY \_\_\_\_\_

OPEN ABDOMINAL SURGERY \_\_\_\_\_

IUI \_\_\_\_\_

IVF \_\_\_\_\_

OTHER \_\_\_\_\_

**IF OTHER THAN INFERTILITY - WHAT IS YOUR MAIN PROBLEM?**

\_\_\_\_\_

HAS ANY OTHER PHYSICIAN DIAGNOSED AND / OR TREATED YOUR PROBLEM?

\_\_\_\_\_

IF YES - WHO \_\_\_\_\_

WHAT TESTS HAVE YOU HAD \_\_\_\_\_

\_\_\_\_\_

WHAT WERE YOU TOLD \_\_\_\_\_

\_\_\_\_\_

WHAT DO YOU THINK IS CAUSING YOUR PROBLEM \_\_\_\_\_

WHAT TREATMENT(S) HAVE YOU BEEN GIVEN \_\_\_\_\_

\_\_\_\_\_

WHAT WOULD YOU LIKE ME TO ACCOMPLISH FOR YOU \_\_\_\_\_

\_\_\_\_\_

DESCRIBE ALL FACTORS WHICH YOU BELIEVE ARE PLAYING A ROLE IN YOUR PROBLEM(S) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE TELL ME HOW IT WAS THAT YOU CHOSE TO COME TO MY OFFICE:

- REFERRED BY PHYSICIAN       REFERRED BY HOSPITAL       RECOMMENDATION BY FRIEND
- RECOMMENDATION BY RELATIVE       CONVENIENT LOCATION       I'M IN YOUR MANAGED CARE PLAN
- REFERRED BY THE ENDOMETRIOSIS ASSOCIATION       INTERNET       WHICH WEBSITE? \_\_\_\_\_
- OTHER       PLEASE EXPLAIN \_\_\_\_\_

WE ARE PROUD TO OFFER A FULL SERVICE MEDSPA WITH A VARIETY OF FDA APPROVED MEDICAL GRADE PRODUCTS AND SERVICES TO TREAT, CORRECT AND PREVENT A RANGE OF SKIN CONDITIONS.

PLEASE INDICATE ANY/ALL SERVICES FOR WHICH YOU WOULD LIKE TO HAVE A FREE CONSULTATION WITH A BREYER MEDSPA REPRESENTATIVE:

- GENERAL SKIN CARE     LASER HAIR REMOVAL     ACNE TREATMENT       PIGMENTATION
- SKIN TIGHTENING/NON-SURGICAL FACE LIFT     SKIN RESURFACING     SCAR
- REDUCTION       VASCULAR THERAPY       CHEMICAL PEELS       MICRODERMABRASION
- ACNE TREATMENT       BOTOX/DERMAL FILLERS     OTHER \_\_\_\_\_

INFORMATION REVIEWED \_\_\_\_\_ DATE \_\_\_\_\_