CONFIDENTIAL FEMALE EVALUATION

Date:____

Name:____ Birth date:_________________________

Age:___________________________ Referred by: ________________________

Marital Status:___________________ Height:_____________________________

Occupation: _____________________ Last Menstrual Period: _____________________________

Reason for today's visit: ____

____

Questions	If YES, how often and how much?	Please Check, NO
Do you use tobacco?		
Do you use alcohol?		
Do you use caffeine?		
Do you exercise?		

List any DRUG allergies and describe the reaction that occurred:____

____

____

Current Prescription Medications:

____

____

____

Over-the-Counter Medications: List all non-prescription medications, vitamins and supplements:

____

____

____

Medical Conditions/Diseases:

____

____
____

Past Surgical History/Date of Surgery:

____
____
____
____

Past Gynecological Surgeries/Date of Surgery/Reason for Surgery:

____
____
____
____

How many pregnancies have you had? ____________________ How many children? _________________

Vaginal Deliveries: ____________________ Cesarean Sections: _____________________________

Delivery complications:

____
____
____

FAMILY HISTORY

RELATIONSHIP	MEDICAL PROBLEM	CURRENT AGE/AGE OF DEATH
Mother		
Father		
Sister		
Brother		
Children		
Other		

Have you had any of the following tests performed?

TEST	YES or NO	DATE	OUTCOME
Mammography			
PAP Smear			
Bone Density			
Colonoscopy			

Other Tests:

____

____

Goals for therapy?

1. ____

2. ____

3. ____

Please list any doctors you have seen within the past year and the reason for the visit:

HEALTHCARE PROVIDER	SPECIALTY	DATE OF SERVICE	REASON

*** Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.

Do you want Dr. Hall to send a copy of your office visit today to any of your providers? YES/NO

If yes, please list the providers:

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