Patient Information

Name: ____ **Date of Birth**: ____________________ **Age**: ______
(Last) (First) (M.I.)

Height: ___________ Most Recent Weight: ___________

Home Address: ____

City: ____________________________________ **State**: _________ **Zip Code**: ____________________________

Home Phone: _____________________________ **Cell Phone**: _________________________________

May we confirm appointments via text? YES NO **Cell Phone Provider**: ______________________________

Email Address: ____

May we contact you via email/remind you of appointments via email? YES NO

Occupation: ____________________________________ **Employer**: ____________________________________

Marital Status (please circle): Single Married Divorced Widowed Living with Partner Other

In Case of Emergency Contact: ____

I authorize the following person(s) to have medical information released to them on my behalf

(Name & Relationship): ____

Primary Care Physician (Name & Phone number): ____

OBGYN (Name & Number): ____

Preferred Pharmacy (Location & Phone number): ____

How did you hear about us (Please circle)?

TV Facebook Web Search Billboards YMCA Elite/Genesis Health

If you were referred, by whom? ____

Signature: ____ **Date**:___________________________

Initial Female Symptom Questionnaire

Name: ______________________________ **Date of Birth:** _______________ **Today's Date:** ______________

Symptom	**----Low----**				**---Moderate---**				**---Severe----**			**Comments:**
Irritability/Anger	0	1	2	3	4	5	6	7	8	9	10	
Anxiety	0	1	2	3	4	5	6	7	8	9	10	
Depressive Mood/Mood Swings	0	1	2	3	4	5	6	7	8	9	10	
Heart: skipping, racing, bounding	0	1	2	3	4	5	6	7	8	9	10	
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	
Non-Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	
Difficulty falling/staying asleep	0	1	2	3	4	5	6	7	8	9	10	
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10	
Night Sweats	0	1	2	3	4	5	6	7	8	9	10	
Bladder Problems: leaking, urgency, frequency	0	1	2	3	4	5	6	7	8	9	10	
Vaginal Dryness: dryness, burning, painful, intercourse	0	1	2	3	4	5	6	7	8	9	10	
Dry, Itchy Skin	0	1	2	3	4	5	6	7	8	9	10	
Restless Legs	0	1	2	3	4	5	6	7	8	9	10	
Hair Issues: loss, thinning, change in texture	0	1	2	3	4	5	6	7	8	9	10	
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	
Poor Memory: forgetfulness	0	1	2	3	4	5	6	7	8	9	10	
Joint Pain/Discomfort	0	1	2	3	4	5	6	7	8	9	10	
Sexual Problems: low libido, decrease orgasm, loss of sensation	0	1	2	3	4	5	6	7	8	9	10	
Chronic Fatigue	0	1	2	3	4	5	6	7	8	9	10	
Low Energy	0	1	2	3	4	5	6	7	8	9	10	
Low Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	
Loss of Muscle Tone	0	1	2	3	4	5	6	7	8	9	10	
Weight Issues	0	1	2	3	4	5	6	7	8	9	10	

List your main health &/or symptom concerns.	When did you first experience these concerns?
1.	
2.	
3.	

How have you dealt with these concerns in the past? – "Doctoring" or Self-Care

How satisfied are you with the care you've sought thus far?

What other health professionals are you actively seeing now?

At what point in your life did you feel your best? Why?

Medical & Family History: Please check column as it applies to you or your family.
Circle specific condition if listed in the left hand column. For family members, write who it is that specifically suffers from the condition in the spaces provided.

Condition	Does NOT apply	Myself	Sibling(s)	Parent(s)	Grandparent(s)
High Blood Pressure					
High Cholesterol					
Heart Disease					
Diabetes: Type 1 or 2					
Cancer: list type					
Blood Disorders (Anemia, Clotting Issues, Varicose Veins, etc.)					
Bloodborne Illness (MRSA, Hepatitis, HIV/AIDS, etc.)					
Mental Illness (Depression, Anxiety, ADHD)					
Autoimmune Disease (Lupus, RA, etc.)					
Arthritis					
Osteoporosis/Osteopenia					
Endocrine Disorders (Thyroid, Adrenal, Pituitary, etc.)					
Allergies/Sensitivities (Environmental, Foods, Gluten, Dairy, etc.)					
Headaches (Migraine, Non-migraine)					
Neurological Disorders (Stroke, Seizures, Parkinson's, Alzheimer's)					
Lung Disease (Asthma, Emphysema, COPD)					
Kidney Disease (stones, infections, etc.)					
Stomach Issues (ulcers, reflux, heartburn, gas/bloating,)					
Bowel Disorders (Chron's, Colitis, IBS, Diverticulitis, Diarrhea, Constipation)					
Bladder Disease					
Liver Disease (Hepatitis, Cirrhosis)					
Substance Abuse					
Weight Control Problems					
Sleep Issues (Insomnia, Apnea, Snoring)					
OTHER: please list:					

Female History:

Symptom/Issue	**Yes**	**No**
Irregular bleeding/bleeding between periods/missed periods		
Painful periods		
Heavy bleeding during period		
PMS symptoms		
Bloating/water retention		
Vaginal Dryness		
Vaginal Itching		
Frequent vaginal or urinary tract infections		
Pelvic or vaginal pain		
Painful intercourse		
Past or present sexually transmitted infection (specify):		
Breast cysts/fibrocystic breasts		
Infertility		
History of ovarian cysts		
Diagnosis of PCOS (Polycystic Ovarian Syndrome)		
History of endometriosis		
Are you currently sexually active?		
Are you pregnant?		
Are you planning to become pregnant?		
Are you breastfeeding or pumping?		
Number of pregnancies:		
Have you had a miscarriage (if yes, how many)?		
Endometrial Ablation? Yes- when?		
Hysterectomy? Yes circle- TOTAL or PARTIAL Write when & why:		
Method of Birth Control currently using: (circle) None Oral Pill Tubal Ligation ("tubes tied") Hysterectomy Condoms Withdrawal Vasectomy Mirena IUD Paraguard IUD Nexplanon Depo Provera Shot		
Birth control users (even if off it now): how long have you been on the pill?		
First day (or year if menopausal) of last period:		
If cycling: How long do your periods typically last?		
How many days between your periods?		

Patient initials:________

Routine Screenings	Date & Results
Last pap smear/pelvic exam/well woman physical/clinical breast exam:	
Do you do self-breast exams on occasion?	
Last mammogram:	
Last colonoscopy:	
Last bone density scan:	

Surgical History (may attach separate sheet if necessary):

Procedure:	Date:

Have you ever had difficulties with anesthesia or numbing (ie; epidurals or during dental procedures): NO YES (please explain)________________________________

Allergies:

Medication/Drug:	Reaction:

Patient initials:________

Please list ALL medications (prescription & over-the-counter) & supplements/vitamins/minerals you are taking & why:

Medication:	For what condition:	Dose:	Times per day:

Any form of current or past hormone therapy (describe)? ________________________________

____

____

How often have you taken antibiotics during:

Infancy/Childhood: ____

Adolescence: ____

Adulthood: ____

Patient initials:________

Lifestyle:

Have you traveled outside the US recently? NO YES- when & where? ______________________

Tobacco Products: YES NO FORMER USER- when did you quit? __________________________

If YES, what product:_________________________ How much/many per day? _______________

Alcohol: NO YES- how many per week on average? ____

Recreational Drugs: NO YES- what type and how often?_______________________________________

Caffeine: NO YES- how many servings per day on average? ___________________________________

Daily water intake: NO YES- how many ounces per day? ____________________________________

Do you have an exercise routine? NO YES- what kind & how often? _________________________

____

Stress level on a daily basis (please circle, 0 low -10 high) **0 1 2 3 4 5 6 7 8 9 10**
Describe your main sources of stress & how you handle your stress: _________________________

____

____

Do you have a support system including friends & family to support you in any lifestyle changes you choose to make? NO YES- ____

____

Have you or a family member recently experienced any major life changes or losses?
If so- please describe? ____

____

Are you interested in a holistic approach to health coaching, including talking about and getting resources for improvement in other areas in your life, like nutrition, weight management, relationships, career, personal growth and spirituality? NO YES

Consent to Treat: Patient authorizes Allure Health & Med Spa provider(s) and/or staff to perform necessary diagnostic exams, procedures, tests, photographs or any other diagnostic aid deemed necessary to make an appropriate diagnosis and perform mutually agreed upon treatments. I agree to proper use of any medication or treatment recommended by my Allure Health & Med Spa provider. I consent that the information contained in this document is accurate and truthful to the best of my knowledge and I take responsibility to advise Allure Health & Med Spa providers and staff of any changes to my medical condition or history. I also agree to continue to pursue management of any routine, preventative screening or chronic illness care not being managed by the Allure Health & Med Spa provider(s) or for those conditions not covered under the Allure Health & Med Spa list of services/scope of practice. Payment for services is required at time of service and is solely the responsibility of the patient. Insurance documentation for personal submission of claims, at patient's discretion, may be provided upon request.

Signature: ____ **Date:** ____________________________