SottoPelle®
Hormonal Balance.Well-Being.
C E R T I F I E D

Female Patient Information

Name: _____ Today's Date: _____
LAST MIDDLE FIRST

Date of Birth: _____ Social Security #: _____

Street address: _____

City: _____ State: _____ Zip:_____

Phone numbers: Home _____ Cell_____

Do you have an email address you can share with us?_____

We would like to stay in contact with you at all times. Please provide us with a summer residence location if you have one: _____

Patient employed by: _____

Business address: _____

Business phone: _____

Marital status: (please circle) Married Divorced Single Widow Living with Sig. Other

Spouse's Name: _____
FIRST LAST

Spouse's date of birth: _____ Social Security #: _____

Spouse employed by: _____ Business phone:_____

In case of emergency, whom should we notify? _____

Phone number(s): _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. In order to control the cost of billing, we request that our charges for office visits be paid at the conclusion of each visit. If this account is assigned to an attorney for collections and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection. I authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and any other insurance to:_____ This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

What is the reason for your visit today? If it is a problem, please describe the symptoms & be specific: _____

_____

OB HISTORY

1. How many times have you been pregnant? ..... _____
2. How many miscarriages have you had? ..... _____
3. How many abortions have you had? ..... _____
4. Have you had any Tubal/Ectopic pregnancies? ..... _____
5. How many vaginal deliveries have you had? ..... _____
6. How many Cesarean Sections have you had? ..... _____
7. Have you had any premature deliveries? ..... _____
8. Have you had any babies weighing less than 5 lb 8 oz at birth? ..... _____
9. How many full term deliveries? ..... _____
10. Have you had any twin births? ..... _____
11. Did you have any complications with your pregnancies? ❑ YES ❑ NO
    If yes, list: _____

_____

_____

GYN HISTORY

1. Are you sexually active? ❑ YES ❑ NO
1a. Have you been sexually active? ❑ YES ❑ NO
2. Do you have pain with intercourse? ❑ YES ❑ NO
3. What type of contraception are you currently using? (CIRCLE BELOW)
   Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
   Foam Vasectomy Diaphragm Implants Other _____
4. What type of contraception have you used in the past? (CIRCLE BELOW)
   Pills Tubal Ligation Condoms Withdrawal Depo Provera IUD
   Foam Vasectomy Diaphragm Implants Other _____
5. Are you having any problems with your method of Birth Control? ❑ YES ❑ NO
6. Have you ever had any vaginal, cervical and/or tubal infection? ❑ YES ❑ NO
   If yes, please check below:
   ❑ Yeast ❑ Gardnerella ❑ Syphllis ❑ Condyloma ❑ Bacterial Vaginitis ❑ PID
   ❑ Herpes ❑ Trichomonas ❑ Chlamydia ❑ Gonorrhea ❑ Warts ❑ Other _____
7. Date of last pap smear? _____
8. Have you ever had an abnormal pap smear? ❑ YES ❑ NO
   If yes, how was it treated? Please check below:
   ❑ Repeated Pap Smear ❑ Colposcopy ❑ Laser Surgery ❑ Cone Biopsy
   ❑ Cryosurgery (freezing) ❑ Hysterectomy ❑ Loop Excision
9. Do you have trouble leaking urine? ❑ YES ❑ NO

10. Do you have any breast lumps, tenderness or discharge? ❑ YES ❑ NO
10a. Have you had a mammogram? ❑ YES ❑ NO
If yes, was it normal? ❑ YES ❑ NO
Date of last mammogram _____
11. Do you do breast self exams? ❑ YES ❑ NO
12. Do you have PMS symptoms? ❑ YES ❑ NO
If yes, any treatment?_____
13. Do you have any hot flashes or menopausal symptoms? ❑ YES ❑ NO
14. Do you have any uterine anomalies? ❑ YES ❑ NO
15. Do you have a history of infertility? ❑ YES ❑ NO
16. Do you have a history of DES exposure? ❑ YES ❑ NO

MENSTRUAL HISTORY

1. If you no longer have periods, please state reason: _____
2. First day of last period: _____
3. How many days does your period last? _____
4. Are your periods regular? ❑ YES ❑ NO
5. How many days from the start of one period to the start of the next period? _____
6. Has the flow changed in any way? _____ If so, how? _____
7. Do you have any bleeding between periods? ❑ YES ❑ NO
8. Do you have any cramping with your periods? ❑ YES ❑ NO
If yes, circle one: mild moderate severe
9. Medicine taken for cramps? _____

SOCIAL HISTORY

1. Do you smoke cigarettes? ❑ YES ❑ NO
If yes, # per day? _____ Number of years? _____
2. Do you use street drugs? ❑ YES ❑ NO
3. Do you drink alcohol? ❑ YES ❑ NO
If yes, how much per day?_____

PAST MEDICAL HISTORY

1. Do you have diabetes? ❑ YES ❑ NO
2. Do you have/had hypertension? ❑ YES ❑ NO
3. Do you have heart disease? ❑ YES ❑ NO
4. Do you have a heart murmur? ❑ YES ❑ NO
5. Do you have/had kidney disease? ❑ YES ❑ NO
6. Have you ever been treated for psychiatric problems? ❑ YES ❑ NO
7. Have you ever had rheumatic fever? ❑ YES ❑ NO
8. Do you have mitral valve prolapse? ❑ YES ❑ NO
9. Have you ever had a urinary tract infection? ❑ YES ❑ NO
10. Have you ever had hepatitis/liver disease? ❑ YES ❑ NO
11. Have you ever had varicosities/phlebitis? ❑ YES ❑ NO
12. Do you have any thyroid problems? ❑ YES ❑ NO
13. Have you had any major accidents? ❑ YES ❑ NO
14. Have you ever had any blood transfusions? ❑ YES ❑ NO
15. Do you have asthma/lung disease? ❑ YES ❑ NO
16. Do you have any Drug Allergies? ❑ YES ❑ NO
    If yes, please list:_____
17. Please list any GYN surgeries:

_____

_____

18. Please list any other operations/hospitalizations (include year & reason):

_____

_____

_____

_____

19. Have you had any anesthesia complications? ❑ YES ❑ NO
    If yes, please list:_____
20. Have you ever been anemic? ❑ YES ❑ NO
21. Do you have an Internist or Family doctor? ❑ YES ❑ NO
    Please list name, phone number:

_____

_____

_____

22. Are you currently on any medications? ❑ YES ❑ NO
    If yes, please list with dosage: _____
23. Have you had your cholesterol checked? ❑ YES ❑ NO
    If yes, date last checked: _____
    Was it normal? ❑ YES ❑ NO
24. Do you have Arthritis? ❑ YES ❑ NO
    If yes, what type? _____
25. Do you have Lupus, Scleroderma or similar diseases? ❑ YES ❑ NO
    If yes, please describe: _____

FAMILY HISTORY

1. Do you have a family history of breast cancer? ❑ YES ❑ NO
   If yes, whom?_____
2. Do you have a family history of colon cancer? ❑ YES ❑ NO
   If yes, whom?_____
3. Do you have a family history of ovarian cancer? ❑ YES ❑ NO
   If yes, whom?_____
4. Do you have a family history of osteoporosis? ❑ YES ❑ NO
   If yes, whom?_____
5. Do you have a family history of diabetes? ❑ YES ❑ NO
   If yes, whom?_____
6. Do you have a family history of hypertension? ❑ YES ❑ NO
   If yes, whom?_____
7. Do you have a family history of heart disease? ❑ YES ❑ NO
   If yes, whom?_____
8. Do you have a family history of kidney disease? ❑ YES ❑ NO
   If yes, whom?_____