INSTRUCTIONS:

This PDF file can be downloaded to your computer or printed on your printer in order to be completed by hand and brought with you to your appointment. If you can scan the completed form, you can email it to **droffice@yahoo.com**. Be sure to include your full name in the body of your email.
Should you have any questions, please contact us at **325.698.8500**.

Thank You!

biofit by Dr. Jordan
Weight & Hormone Clinic

rev. 02.05.2023

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Weight & Hormone Clinic

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name _____ Today's Date _____
[Last] [First] [Middle]

Date of Birth _____ Age _____ Weight _____ Occupation _____

Home Address _____

City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____ May we contact you via Email? ☐ Yes ☐ No

In case of Emergency Contact _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Primary Care Physician's Name _____ Phone _____

Address/City/ tate/Zip _____

Marital Status [check one] ☐ Married ☐ Divorced ☐ Widow ☐ Living with Partner ☐ Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name _____ Relationship _____

Home Phone _____ Cell Phone _____ Work Phone _____

Social:

- ☐ I am sexually active.
- ☐ I want to be sexually active.
- ☐ I have completed my family.
- ☐ My sex has suffered.
- ☐ I haven't been able to have an orgasm.

Habits:

- ☐ Smoke cigarettes or cigars _____ per day.
- ☐ Drink alcoholic beverages _____ per week.
- ☐ Drink more than 10 alcoholic beverages a week.
- ☐ Use caffeine _____ day.

[*If needed, add additional details on page 4*]

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MEDICAL HISTORY

Any known drug allergies? [list them] _____

Have you ever had any issues with anesthesia? ☐ Yes ☐ No

If yes, please explain _____

Medications currently taking _____

Current Hormone Replacement Therapy _____

Past Hormone Replacement Therapy _____

Nutritional / Vitamin Supplements _____

Surgeries [list all and when] _____

Last Menstrual Period [estimate year if unknown] _____

Other Pertinent Information _____

Preventative Medical Care:

- ☐ Medical / GYN exam in the last year
- ☐ Mammogram in the last 12 months
- ☐ Bone Density in the last 12 months
- ☐ Pelvic Ultrasound in the last 12 months

High Risk Past Medical/Surgical History:

- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Hysterectomy with removal of Ovaries
- ☐ Hysterectomy only
- ☐ Oophorectomy removal of Ovaries

Birth Control Method:

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Tubal Ligation
- ☐ Birth Control Pills
- ☐ Vasectomy
- ☐ Other _____

Medical Illnesses:

- ☐ Polycystic Ovary Syndrome [PCOS}
- ☐ High Blood Pressure
- ☐ Heart Bypass
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Stroke and/or Heart Attack
- ☐ Blood Clot and/or a Pulmonary Embolism
- ☐ Arrhythmia
- ☐ Any form of Hepatitis or HIV
- ☐ Lupus or other Auto-Immune Disease
- ☐ Fibromyalgia
- ☐ Trouble passing Urine or take Flomax or Avodart
- ☐ Chronic Liver Disease [Hepatitis, Fatty Liver, Cirrhosis]
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Depression / Anxiety
- ☐ Psychiatric Disorder
- ☐ Cancer [type] _____ Year _____

[*If needed, add additional details on page 4*]

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HEALTH ASSESSMENT FOR WOMEN

Name _____ Date _____

Email Address _____

SYMPTOMS [please check box]	NEVER	MILD	MODERATE	SEVERE
1) Fatigue	☐	☐	☐	☐
2) Mood Changes *Irritability* *Anxiety / Nervousness* *Depression*	☐	☐	☐	☐
3) Decreased Mental Ability *Memory Loss* *Confusion* *Loss of Focus*	☐	☐	☐	☐
4) Hot Flashes / Night Sweats	☐	☐	☐	☐
5) Weight Gain *Bloating* *Excessive Belly Fat* *Inability to Lose Weight*	☐	☐	☐	☐
6) Decreased Sex Drive *Vaginal Dryness*	☐	☐	☐	☐
7) Sleep Problems *Can't Stay Asleep* *Can't Fall Asleep*	☐	☐	☐	☐
8) Cold Hands & Feet / Always Cold	☐	☐	☐	☐
9) Hair Loss / Breakage	☐	☐	☐	☐
10) Dry Wrinkled Skin	☐	☐	☐	☐

FAMILY HISTORY [please check box]	NO	YES
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Breast Cancer	☐	☐

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ADDITIONAL DETAILS