OBGYN History

Patient Name: ______________________________ Today's Date: ______________

What is the reason for your visit today? Please describe any specific symptoms you may be experiencing.

____

OB HISTORY:

How may times have you been pregnant? ______________

How many miscarriages have you had? ______________

Did you have any complications with your pregnancies? ❒ Yes ❒ No

If Yes, please explain: ____

____

GYN HISTORY:

1. Are you sexually active? ❒ Yes ❒ No

Have you experienced any problems related to intercourse? ❒ Yes ❒ No

If Yes, please explain: ____

____

Have you tried or are you currently using hormone creams, pills, or supplements?

Explain: ____

3. If premenopausal: What type of contraception are you currently using?

❒ Pills ❒ Tubal Ligation ❒ Condoms ❒ Depo Provera ❒ IUD ❒ Foam ❒ Vasectomy ❒ Diaphragm ❒ Implants ❒ Nothing

Other: ____

4. What type of contraception have you used in the past?

❒ Pills ❒ Tubal Ligation ❒ Condoms ❒ Withdrawal ❒ Depo Provera ❒ IUD ❒ Foam ❒ Vasectomy ❒ Diaphragm ❒ Implants

Other: ____

If premenopausal: Date (first day) of Last Menstrual Cycle: ____________________

Menses: ❒ Light ❒ Heavy ❒ Varies   Menstrual Cramping: ❒ Light ❒ Medium ❒ Heavy

Patient Profile (1 of 2)

First Name: ______________________________ Last Name: ____

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed Date of Birth: ______________________________

Email: ____ May we contact you by email? ❒ Yes ❒ No

Street Address: ____

City: ____ State: _______________________________ Zip: ___________________________

Telephone: _____________________________ Day Phone: _____________________________ Cell Phone: __________________________

Occupation: _____________________________ Employer: _____________________________ Cell Phone: __________________________

Ethnicity: ❒ African American ❒ Asian ❒ Caucasian ❒ Hispanic ❒ Native American ❒ Middle Eastern Other:__________________

Emergency Contact: ___________________________________ Phone Number: ____________________________ Relationship: ____________

Spouse/Partner Name: (if applicable) ____ Phone Number: ___________________________

Spouse Employer: ____ Address/Phone Number: ___________________________________

How did you hear about us? ____

What are your expectations of Bioidentical hormone treatments? ____

Check all that apply:

❒ Anxiety
❒ Autoimmune Disease
❒ Cancer
❒ Endocrine Disorder
❒ Hepatitis
❒ Prostate Surgery
❒ Mood Swings
❒ HRT
❒ Thinning Hair
❒ Blood Clots
❒ Liver Disease
❒ Aches/Pains
❒ Palpitations
❒ Hypertension
❒ Shingles
❒ Diabetes
❒ Thyroid Disorder
❒ Weight Gain
❒ Erectile Dysfunction
❒ Jaundice
❒ High Cholesterol
❒ Night Sweats
❒ Blood Diseases
❒ Dry Skin
❒ Heart Disease
❒ Vasectomy
❒ Restless Leg Syndrome
❒ Suffered Stroke
❒ PMS
❒ Renal Disease
❒ Low Blood Pressure
❒ Smoker
❒ Alcohol Drinker _______________________ (Per Week?)

Height:__________ Weight:__________ Desired Weight:__________ Are you presently dieting? ❒ Yes ❒ No Which Diet? ________________

Current Meds, Vitamins, or Herbal Remedies: ____

Surgical History: ____

Patient Profile (2 of 2)

First Name: ___________________________________ Last Name: ____

Primary Care Physician: ____ Phone: ______________________________

Street Address: ____

City: ____ State: ________________________________ Zip: ___________________________

Do you exercise regularly? ❒ Yes ❒ No What exercise program do you follow? ____

How often do you work out? ____

What other activities do you do in your leisure time? ____

Do you play any sports? ❒ Yes ❒ No What sports do you play? ____

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I hereby authorize Dr. Huber to apply for benefits on my behalf for services rendered by him. I request payment from my insurance company (companies) to be made to Dr. Huber. I understand that if my insurance covers only a portion of the charges, I will be responsible for the balance of the fees. I also understand that if the insurance claim is denied, I will be billed for the entire amount of the charges. If payment is not made by my insurance company within sixty (60) days from the date of the claim submission, I agree to promptly pay in full any amounts due to Dr. Huber. If full payment of the outstanding balance on my account is not paid within sixty (60) days of notification, I agree to pay any interest and/or late charges levied on my balance. In the event my account becomes overdue, I will be responsible for attorney's fees as well as expenses which are related to collection efforts.

I certify that the information I have read with regard to my insurance coverage is correct and authorize the release of any information, including medical information and photographs, to my insurance company (companies).

Please print name: ____

The above information is true to the best of my knowledge:

PLEASE SIGN ____ Date ________________________

Symptoms (Female)

Patient's Name: ______________________________ Today's Date: ______________

SYMPTOM	NONE	OCCASIONAL	MODERATE	SEVERE
Hot Flashes				
Fatigue				
Night Sweats				
Low Libido				
Insomnia				
Irritable				
Mood Swings				
Weight Gain				
Depression				
Anxiety				
Difficulty Losing Weight				
Poor Exercise Tolerance				
Cold Body Temperature				
Cold Hands & Feet				
Hair Loss				
Joint Pain				
Loss of Muscle Mass				
Visual Changes				
Panic Attacks				
Breakthrough Bleeding				
Vaginal Dryness				
Memory Lapses				
Bone Loss				
Water Retention				
Dry Skin				
Urinary Incontinence				
Headaches				
Tearful				
Thinning Skin				
Uterine Fibroid				
Cystic Ovaries				
Foggy Thinking				
Increased Facial Hair				
Oily Skin				
Allergies				
Acne				
Heart Disease				
Decreased Concentration				
Insulin Resistance				
Swelling/Puffy Eyes				
Sugar Craving				
High Blood Sugars				

2522 Maple Grove Road • Duluth, MN 55811 • **218.206.9278**