NOW health
North Okanagan Women's Health

New Patient Intake Form

Please answer the following questions as best you can. Don't worry if some of the information is missing. Keep your answers brief. Bring your completed questionnaire to our office on the day of your appointment. Dr. Hatfield will review your answers prior to your consultation.

Name ____ Age ____________
Referring physician ___________________________ Date ____________

What are your top 3 health goals?
1. ________________________
2. ________________________
3. ________________________

Reason For Consultation
Why are you coming to see Dr. Hatfield? (be brief)

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If you have seen another healthcare provider other than your family doctor for this problem, please tell us the details:
Who you saw: ____________________________ Approximate Date ____________________

What treatment did you receive? Was it helpful? Explain.

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Office Use only

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Please rate each symptom you are experiencing as mild, moderate or severe. If you do not have a symptom, tick none.

Estrogen	**Total ________**
Night sweats or hot flashes	☐none ☐ mild ☐ moderate ☐ severe
Difficulty falling and/or staying asleep	☐none ☐ mild ☐ moderate ☐ severe
Un-refreshed sleep	☐none ☐ mild ☐ moderate ☐ severe
Vaginal dryness	☐none ☐ mild ☐ moderate ☐ severe
Painful sex	☐none ☐ mild ☐ moderate ☐ severe
Low sex drive	☐none ☐ mild ☐ moderate ☐ severe
Orgasms less frequent or intense	☐none ☐ mild ☐ moderate ☐ severe
Leaky or overactive bladder	☐none ☐ mild ☐ moderate ☐ severe
Frequent bladder infections	☐none ☐ mild ☐ moderate ☐ severe
Anxiety	☐none ☐ mild ☐ moderate ☐ severe
Mood swings or irritability	☐none ☐ mild ☐ moderate ☐ severe
Depressed mood or feeling “flat”	☐none ☐ mild ☐ moderate ☐ severe
Lost the “joy of living”	☐none ☐ mild ☐ moderate ☐ severe
Less social than before	☐none ☐ mild ☐ moderate ☐ severe
No motivation to get out there and do things	☐none ☐ mild ☐ moderate ☐ severe
Poor memory or forgetful (brain fog)	☐none ☐ mild ☐ moderate ☐ severe
Difficulty finding words or completing sentences	☐none ☐ mild ☐ moderate ☐ severe
No enthusiasm for physical activity	☐none ☐ mild ☐ moderate ☐ severe
Premenstrual migraine headaches?	☐none ☐ mild ☐ moderate ☐ severe
Periods getting lighter	☐none ☐ mild ☐ moderate ☐ severe
Dry, itchy skin	☐none ☐ mild ☐ moderate ☐ severe
Hair loss from scalp	☐none ☐ mild ☐ moderate ☐ severe
Adult acne	☐none ☐ mild ☐ moderate ☐ severe
Body and joint pain, especially before periods	☐none ☐ mild ☐ moderate ☐ severe
Droopy breasts or breasts losing volume	☐none ☐ mild ☐ moderate ☐ severe
Sun damage on your face, chest and shoulders	☐none ☐ mild ☐ moderate ☐ severe
Dry eyes	☐none ☐ mild ☐ moderate ☐ severe
Unexplained weight gain	☐none ☐ mild ☐ moderate ☐ severe

Testosterone	**Total ________**
Decreased interest in sex	☐none ☐ mild ☐ moderate ☐ severe
Takes longer to reach orgasm	☐none ☐ mild ☐ moderate ☐ severe
Orgasms less intense than before	☐none ☐ mild ☐ moderate ☐ severe
Nipples and/or clitoris less sensitive	☐none ☐ mild ☐ moderate ☐ severe
Lost sense of vitality	☐none ☐ mild ☐ moderate ☐ severe
Feelings of insecurity	☐none ☐ mild ☐ moderate ☐ severe
Difficulty setting boundaries	☐none ☐ mild ☐ moderate ☐ severe
Less assertive than before	☐none ☐ mild ☐ moderate ☐ severe
Unable to maintain or build muscle	☐none ☐ mild ☐ moderate ☐ severe
No interest in exercise	☐none ☐ mild ☐ moderate ☐ severe
Loss of pubic/underarm hair	☐none ☐ mild ☐ moderate ☐ severe

Progesterone **Total ________**

Water retention before your period ☐none ☐ mild ☐ moderate ☐ severe
Painful and/or swollen breasts ☐none ☐ mild ☐ moderate ☐ severe
Anxiety, especially before your period ☐none ☐ mild ☐ moderate ☐ severe
Insomnia/disrupted sleep before or during your period ☐none ☐ mild ☐ moderate ☐ severe

Irregular or frequent periods ☐none ☐ mild ☐ moderate ☐ severe
Spotting before your period ☐none ☐ mild ☐ moderate ☐ severe
Heavy periods ☐none ☐ mild ☐ moderate ☐ severe
Severe menstrual cramps ☐none ☐ mild ☐ moderate ☐ severe

Weepiness ☐none ☐ mild ☐ moderate ☐ severe
Less calm than you used to be ☐none ☐ mild ☐ moderate ☐ severe
Rapid weight gain in the hips and butt ☐none ☐ mild ☐ moderate ☐ severe

Ovarian cysts, breast cysts or uterine polyps ☐none ☐ mild ☐ moderate ☐ severe
Difficulty conceiving a pregnancy ☐none ☐ mild ☐ moderate ☐ severe
More than one miscarriage in the first trimester ☐none ☐ mild ☐ moderate ☐ severe
Abnormal Pap smears ☐none ☐ mild ☐ moderate ☐ severe
Uterine fibroids ☐none ☐ mild ☐ moderate ☐ severe
Endometriosis ☐none ☐ mild ☐ moderate ☐ severe

Thyroid **Total ________**

Hair loss from scalp ☐none ☐ mild ☐ moderate ☐ severe
Loss of the outer third of your eyebrows ☐none ☐ mild ☐ moderate ☐ severe
Dry skin ☐none ☐ mild ☐ moderate ☐ severe
Dry, strawlike hair that tangles easily ☐none ☐ mild ☐ moderate ☐ severe
Thin nails that break or peel ☐none ☐ mild ☐ moderate ☐ severe
Fluid retention or swollen ankles ☐none ☐ mild ☐ moderate ☐ severe
An additional few pounds that you just cannot lose ☐none ☐ mild ☐ moderate ☐ severe
High cholesterol ☐none ☐ mild ☐ moderate ☐ severe
Bowel movements less often than once a day ☐none ☐ mild ☐ moderate ☐ severe
Recurrent headaches ☐none ☐ mild ☐ moderate ☐ severe
Decreased sweating ☐none ☐ mild ☐ moderate ☐ severe
Muscle or joint aches ☐none ☐ mild ☐ moderate ☐ severe
Tingling in your hands and feet ☐none ☐ mild ☐ moderate ☐ severe
Cold hands and feet ☐none ☐ mild ☐ moderate ☐ severe
A sensitivity to cold ☐none ☐ mild ☐ moderate ☐ severe
A heart rate less 60 beats per minute ☐none ☐ mild ☐ moderate ☐ severe
Lethargy ☐none ☐ mild ☐ moderate ☐ severe
Fatigue, particularly in the morning ☐none ☐ mild ☐ moderate ☐ severe
Slow brain, slow thoughts ☐none ☐ mild ☐ moderate ☐ severe
Difficulty concentrating ☐none ☐ mild ☐ moderate ☐ severe
Low sex drive ☐none ☐ mild ☐ moderate ☐ severe
Depression ☐none ☐ mild ☐ moderate ☐ severe
Heavy periods ☐none ☐ mild ☐ moderate ☐ severe
A family history of thyroid problems ☐none ☐ mild ☐ moderate ☐ severe

Cortisol and DHEA **Total ________**

Symptom				
Fatigue or burnout	☐none	☐ mild	☐ moderate	☐ severe
Loss of stamina	☐none	☐ mild	☐ moderate	☐ severe
Decreased stress tolerance	☐none	☐ mild	☐ moderate	☐ severe
Depression	☐none	☐ mild	☐ moderate	☐ severe
Insomnia or difficulty staying asleep	☐none	☐ mild	☐ moderate	☐ severe
Low blood pressure	☐none	☐ mild	☐ moderate	☐ severe
Feeling dizzy when you stand up from lying down	☐none	☐ mild	☐ moderate	☐ severe
Difficulty fighting infection	☐none	☐ mild	☐ moderate	☐ severe
Decreased problem solving ability	☐none	☐ mild	☐ moderate	☐ severe
Difficulty recovering from illness or healing wounds	☐none	☐ mild	☐ moderate	☐ severe
New allergies	☐none	☐ mild	☐ moderate	☐ severe
Low or unstable blood sugar	☐none	☐ mild	☐ moderate	☐ severe
Salt cravings	☐none	☐ mild	☐ moderate	☐ severe
Excess sweating	☐none	☐ mild	☐ moderate	☐ severe
Muscle weakness	☐none	☐ mild	☐ moderate	☐ severe
Muscle or joint pain	☐none	☐ mild	☐ moderate	☐ severe
Low sex drive	☐none	☐ mild	☐ moderate	☐ severe

Pregnenolone **Total ________**

Symptom				
More forgetful than before	☐none	☐ mild	☐ moderate	☐ severe
Not as sharp mentally	☐none	☐ mild	☐ moderate	☐ severe
Afraid to share your opinion	☐none	☐ mild	☐ moderate	☐ severe
Lack social confidence	☐none	☐ mild	☐ moderate	☐ severe
Family history of Alzheimer’s disease	☐none	☐ mild	☐ moderate	☐ severe
Depressed mood	☐none	☐ mild	☐ moderate	☐ severe
Difficulty seeing colours clearly	☐none	☐ mild	☐ moderate	☐ severe
Arthritis/joint pain	☐none	☐ mild	☐ moderate	☐ severe
Lack physical energy	☐none	☐ mild	☐ moderate	☐ severe
elevated cholesterol	☐none	☐ mild	☐ moderate	☐ severe

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Gynecologic History
Date of last menstrual period _______________

skip questions a-g if you your periods have stopped

a) How many days from the start of one period to the start of the next? _________
b) How many days of bleeding? _________
c) Describe your flow? ❑light ❑moderate ❑heavy
d) Do you pass clots? ❑yes ❑no
e) Are you tired during/after your period? ❑yes ❑no
f) Is there bleeding between periods? ❑yes ❑no
g) Do you have pain with your periods? ❑yes ❑no

Age when periods started ________
Have you ever used the birth control pill? ❑yes ❑no
Why did you take it? ______________________ Duration of use ________________________
Describe side effects____
____

Have you ever been diagnosed with or seen a specialist for any of the following conditions?

❑heavy/irregular periods	❑uterine cancer	❑endometriosis
❑pelvic pain	❑ovarian cyst	❑infertility
❑fibroids	❑ovarian cancer	❑ectopic pregnancy
❑fibrocystic breasts	❑abnormal Pap smear	❑vaginal prolapse
❑breast cancer	❑polycystic ovarian syndrome	❑incontinence

Have you had any of these procedures?

❑hysterectomy - ❑abdominal ❑vaginal	year______	❑laparoscopy	year______
❑removal of ovary - ❑single ❑both	year______	❑D&C	year______
❑vaginal repair or bladder lift	year______	❑cone biopsy/LEEP	year______
❑incontinence surgery (vaginal tape)	year______	❑tubal ligation	year______
❑fibroid ablation or removal	year______	❑breast biopsy	year______
❑endometrial ablation	year______	❑mastectomy	year______

Obstetrical History
Age at first pregnancy _________
Total pregnancies (including miscarriages/abortions) _________
Number of vaginal deliveries _________ Number of C-sections _________
Describe any obstetrical complications ____
____
____

Sexual History
Are you sexually active? ❑yes ❑no What is your sexual preference? ❑men ❑women
Do you experience pain with intercourse? ❑yes ❑no
Current contraception: ❑nothing ❑pill ❑IUD ❑condoms ❑tubes tied ❑ vasectomy
Have you ever had: ❑Chlamydia ❑Gonorrhea ❑genital warts ❑herpes

Have you ever been sexually abused/assaulted? (answers are confidential)
❑no ❑yes If yes, have you received counseling? ❑yes ❑no
Are you currently in an abusive relationship? (answers are confidential)
❑no ❑yes If yes, would you like crisis intervention information? ❑yes ❑no

Past Medical History

Have you been diagnosed and/or treated for any of the conditions listed below? (check all that apply and provide brief details including medications, investigations and procedures)

	year	details
❑heart attack	______	______________________________
❑stroke	______	______________________________
❑palpitations	______	______________________________
❑high blood pressure	______	______________________________
❑blood clot in leg	______	______________________________
❑bleeding disorder	______	______________________________
❑anemia/low iron	______	______________________________
❑thyroid disease	______	______________________________
❑diabetes	______	______________________________
❑Crohn's/colitis	______	______________________________
❑celiac	______	______________________________
❑diverticulosis	______	______________________________
❑irritable bowel syndrome	______	______________________________
❑bladder infections	______	______________________________
❑kidney disease	______	______________________________
❑liver disease	______	______________________________
❑gallstones	______	______________________________
❑depression	______	______________________________
❑anxiety	______	______________________________
❑fibromyalgia	______	______________________________
❑chronic fatigue	______	______________________________
❑autoimmune disease	______	______________________________
❑cancer	______	______________________________
❑osteoporosis	______	______________________________
❑other	______	______________________________

List any surgical procedures you have had (other than gynecologic):

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Allergies
List any drugs you are allergic to: ____

Medications
List any prescription and over the counter medications you take regularly:

name	dose	name	dose
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

Supplements
List any vitamins and herbs you take regularly:

name	dose	name	dose
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

Family History
How old was your mother when her periods stopped? ________ ❑ don't know
Have any of your relatives used hormones? ❑yes ❑no
What was their experience? ____
____

Mother ❑alive , age _____ ❑deceased at age _____ cause of death ________________
Father ❑alive , age _____ ❑deceased at age _____ cause of death ________________

Check any of the conditions below that have occurred in your family (other than you) and indicate who was affected:

❑blood clot in leg ________________
❑stroke ________________
❑heart disease ________________
❑thyroid ________________
❑diabetes ________________
❑breast cancer ________________
❑ovarian cancer ________________
❑uterine cancer ________________
❑colon cancer ________________
❑prostate cancer ________________
❑other cancer ________________

❑endometriosis ________________
❑ovarian cysts ________________
❑fibroids ________________
❑hysterectomy ________________
❑osteoporosis ________________
❑obesity ________________
❑depression ________________
❑wheat allergy ________________
❑Alzheimer's ________________
❑alcoholism ________________

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Lifestyle

❑single ❑married ❑common law

❑live alone ❑live with partner/spouse ❑children at home, ages ________________

Do you currently smoke? ❑yes ❑no If yes, how many per day? ________

If you previously smoked, when did you quit? ________

How many alcoholic drinks per day ________ week ________

Do you use any drugs ❑yes ❑no

If yes, which ones and how often? ________________________________

How much exercise do you get? (check all that apply)

❑none ❑less than 30 min ❑walking ________ days/wk

❑1-2 days/wk ❑30-45 min per workout ❑weights ________ days/wk

❑3-4 days/wk ❑45 min or more per workout ❑aerobic ________ days/wk

❑5-7 days/wk ❑stretch ________ days/wk

What time do you go to bed? ____________ What time do you rise for the day? ____________

On average, how many hours of solid sleep do you get each night? ________

Which of these events has affected you in your lifetime? (tick all that apply)

❑family violence ❑alcoholic parents

❑major personal illness ❑illness or death of parent, child or spouse

❑retirement or loss of job (in last 5 years) ❑move to a new city (in last 5 years)

Circle the level of stress you are experiencing **daily** on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major cause(s) of stress (e.g. job, family tension, finances, etc):

____

____

Do you have a regular spiritual practice? ❑yes ❑no

Current occupation ____

If retired, former occupation ____________________________________

Are you currently, or have you ever been, exposed to potentially harmful substances at your workplace (pesticides, solvents, radioactivity)? ❑yes ❑no

Describe ____

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Office Use

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Health Screening

Please indicate the date you last had the following tests, describe any abnormalities found and treatment received:

	date	results
Pap smear	____________	____
Mammogram	____________	____
Bone Density	____________	____

Other

Describe any fears/concerns you may have about hormone replacement therapy:

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We offer anti-aging, laser and aesthetic treatments. Please indicate any that interest you:

❑laser hair or vein removal ❑acne/rosacea ❑wart or fungus removal

❑body contouring ❑hCG weight loss ❑anti-snoring

❑skin rejuvenation ❑skin tightening ❑pigmentation/sun damage

❑dermal fillers ❑botox ❑PRP facial

❑vaginal rejuvenation ❑incontinence ❑sexual enhancement

How did you hear about this clinic?

❑family doctor ❑facebook ❑newspaper ❑radio

❑website ❑magazine ❑ friend/family

If you would you like to receive our electronic newsletter, please provide your email address:

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3 Day Diet Journal

Please record your food and fluid intake for 3 days. Do not try to be "good" or change your usual habits. We want this to reflect your normal diet and routine. This will allow us to make better dietary recommendations to improve your health and hormone balance.

Day 1
Wake Up Time _________
Morning Meal Time _________
Morning Snack Time ________
Midday Meal Time _________
Afternoon Snack Time _________
Evening Meal Time _________
Evening Snack Time _________
Fluid Intake

1. Make note of the time you wake up.

2. List and describe in detail all food and drinks, including the amount of each. Be sure to list everything, including condiments. Make note as to whether the food was fresh, frozen, canned, raw, cooked, etc.

3. Note the time of each meal and snack.

4. Record any strong feelings, symptoms or changes in energy that may arise either between meals or relative to foods you are consuming (happiness, sadness, indigestion, fatigue, sleep quality)

5. Keep track of water, coffee, tea and other drinks and record as mL or oz.

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Day 2
Wake Up Time _________
Morning Meal Time _________
Morning Snack Time ________
Midday Meal Time _________
Afternoon Snack Time _________
Evening Meal Time _________
Evening Snack Time _________
Fluid Intake

1. Make note of the time you wake up.

2. List and describe in detail all food and drinks, including the amount of each. Be sure to list everything, including condiments. Make note as to whether the food was fresh, frozen, canned, raw, cooked, etc.

3. Note the time of each meal and snack.

4. Include any strong feelings, symptoms or changes in energy that may arise either between meals or relative to foods you are consuming (happiness, sadness, indigestion, fatigue)

5. Keep track of water, coffee, tea and other drinks and record as mL or oz.

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Day 3
Wake Up Time _________
Morning Meal Time _________
Morning Snack Time ________
Midday Meal Time _________
Afternoon Snack Time _________
Evening Meal Time _________
Evening Snack Time _________
Fluid Intake

1. Make note of the time you wake up.

2. List and describe in detail all food and drinks, including the amount of each. Be sure to list everything, including condiments. Make note as to whether the food was fresh, frozen, canned, raw, cooked, etc.

3. Note the time of each meal and snack.

4. Include any strong feelings, symptoms or changes in energy that may arise either between meals or relative to foods you are consuming (happiness, sadness, indigestion, fatigue)

5. Keep track of water, coffee, tea and other drinks and record as mL or oz.

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