Patient Intake Form For Women

Please complete this form thoroughly, and use extra pages if needed. Please also send along any recent labs.

Name:
Date of Birth:
Address:
Phone number:
Ontario Health Card Number:
Occupation (please include some description of your daily work activity and include any exposure to hazardous materials, significant seated screen time, etc.):

Relationship status:
Height, Weight:
Waist measurement:
Last blood pressure if known:
Primary Care Provider:
Other Health Care Providers:
Allergies:

What are your current health concerns? Please list in priority, note how long you have had these health concerns, what treatments you have tried for these concerns, and the results of the treatments? If you have consulted other healthcare providers for these concerns please include the recommendations and outcome of any treatments advised.

Please note what treatment(s) you are interested in.

Please note your current medical diagnosis, or any current health concerns that you are seeking investigation for.

Please list any current medications including supplements.

Please describe your current diet.

Please describe your digestive health pattern — constipation, reflux, diarrhea?

Please describe your exercise patterns.

Please describe your sleep and whether you have difficulty falling asleep, staying asleep, or waking up rested.

Please note your past medical history.

Please describe your family history, include all cancers, cardiovascular disease, blood pressure or cholesterol problems.

What are your plans for your fertility?

Please note any questions you have about BHRT.

Are you up to date on all recommended cancer screenings? Please be advised that NP Melissa does not provide ongoing primary care and that it Is essential for you to remain up to date on recommended screenings, and to promptly report to Melissa any new or concerning symptoms.

Please complete this questionnaire.
Please rate each symptom from 0-4
0 none
1 mild
2 moderate
3 severe
4 extremely severe

1. Hot flashes, sweating
2. Heart discomfort (tightness, skipping, racing)
3. Sleep problems (difficulty falling asleep, staying asleep, or waking too early)
4. Depressive mood
5. Irritability (tension, nervousness, aggression)
6. Anxiety (restlessness, feeling inner panic)
7. Physical and mental exhaustion (decreases in performance, impaired memory, decrease in concentration, forgetfulness)
8. Sexual problems (change in sexual desire, sexual activity and satisfaction)
9. Bladder problems (difficulty urinating, increased need to urinate, incontinence)
10. Dryness of vagina, burning, difficulty with sexual intercourse
11. Joint and muscle discomfort (pain in joints)