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YEARLY QUESTIONNAIRE

HAVE YOU CHANGED YOUR INSURANCE? NO YES
WILL YOUR INSURANCE CHANGE IN THE NEAR FUTURE? NO YES

IF YES, PLEASE MAKE SURE WE HAVE COPIES OF YOUR CARDS.

NAME _____ AGE _____ DATE _____

MAIN REASON FOR YOUR VISIT: INFERTILITY ENDOMETRIOSIS PELVIC PAIN
IRREGULAR/ABNORMAL BLEEDING EXCESS HAIR ACNE MENOPAUSE
FIBROID TUMORS OSTEOPOROSIS THYROID PROBLEM GYN CARE PCOS
OTHER PROBLEM WHAT _____

LAST NORMAL MENSTRUAL PERIOD ? _____ N/A **TAKING BCP NOW**

PERIODS NOW: MONTHLY IRREGULAR HOW IRREGULAR _____

RECENT CHANGE IN PERIODS? NO YES SINCE WHEN _____

HEAVIER LIGHTER MORE IRREGULAR OTHER _____

LENGTH OF FLOW _____ AMOUNT OF FLOW _____

SPOT/STAIN:	BEFORE PERIOD	NO <input type="checkbox"/>	YES <input type="checkbox"/>
	AFTER PERIOD	NO <input type="checkbox"/>	YES <input type="checkbox"/>
	IN-BETWEEN	NO <input type="checkbox"/>	YES <input type="checkbox"/>

POST MENOPAUSAL: NO YES WHAT AGE _____ NATURAL HYSTERECTOMY

IF SO, ARE YOU ON HORMONES? NO YES

WHICH _____ DOSE _____

ANY BLEEDING? NO YES IF YES, DESCRIBE _____

ARE YOU HAVING HOT FLASHES? NIGHT SWEATS? MOOD SWINGS?

VAGINAL DRYNESS? PAINFUL INTERCOURSE?

PELVIC PAIN, LOW BACK PAIN, OR CRAMPS WITH YOUR PERIODS?

N/A NO YES

HOW BAD ON A SCALE OF 1-10: LESS 1 2 3 4 5 6 7 8 9 10 MORE

PAIN BEGINS BEFORE FLOW? NO YES

HOW LONG BEFORE? 1 DAY 2-4 DAYS 5-7 DAYS 8-10 DAYS 10-14 DAYS MORE

HOW MANY DAYS INTO FLOW DOES THE PAIN LAST:

1-2 DAYS 3-4 DAYS 5-6 DAYS ENTIRE FLOW

PAIN PERSISTS AFTER THE FLOW ENDS NO YES

PAIN IS GETTING WORSE NO YES

WHERE DO YOU FEEL THE PAIN THE MOST _____

WHERE ELSE DO YOU FEEL IT _____

DURING PERIOD, DO YOU HAVE PAIN IN THE RECTUM? NO YES
VAGINA? NO YES

PELVIC PAIN OR CRAMPS AT ANY OTHER TIME? NO YES

HOW BAD? LESS 1 2 3 4 5 6 7 8 9 10 MORE

EVERY DAY FREQUENTLY OCCASIONALLY

MAIN LOCATION _____ OTHER LOCATIONS _____

PAIN IS: SHARP DULL STEADY PRESSURE BURNING

CRAMPY CONSTANT INTERMITTENT OTHER _____

IS THERE ANY PATTERN TO THE PAIN _____

PAIN BETWEEN PERIODS THE SAME AS PAIN WITH YOUR PERIODS OR DIFFERENT

PAIN "SHOOTS" TO OTHER LOCATIONS? WHERE _____

WHAT MAKES PAIN WORSE _____

WHAT MAKES PAIN BETTER _____

NAME _____

WHAT EFFECT DO THE FOLLOWING HAVE ON THE PAIN? URINATION _____

BOWEL MOVEMENTS _____ SEX _____

PHYSICAL ACTIVITY _____

DESCRIBE THE PAIN _____

PAIN DURING SEX? NOT SEXUALLY ACTIVE NO YES

SEX IS: ALWAYS PAINFUL 1 2 3 4 5 6 7 8 9 10

USUALLY PAINFUL 1 2 3 4 5 6 7 8 9 10

SOMETIMES PAINFUL 1 2 3 4 5 6 7 8 9 10

PAIN ON INITIAL ENTRY 1 2 3 4 5 6 7 8 9 10

PAIN ON FULL PENETRATION 1 2 3 4 5 6 7 8 9 10

PAIN PERSISTS AFTER INTERCOURSE 1 2 3 4 5 6 7 8 9 10

DOES PAIN VARY WITH POSITION 1 2 3 4 5 6 7 8 9 10

VARIES WITH THE TIME OF THE CYCLE 1 2 3 4 5 6 7 8 9 10

INTERCOURSE WOULD BE PAINFUL BUT I HAVE

LEARNED HOW TO AVOID THE PAIN 1 2 3 4 5 6 7 8 9 10

1= LESS SEVERE 10=MORE SEVERE

IF PAINFUL, WHERE DO YOU FEEL THE PAIN _____

PAIN FELT DURING INTERCOURSE, AFTER INTERCOURSE, OR BOTH _____

IF AFTER, HOW LONG DOES THE PAIN PERSIST _____

DOES THE SEVERITY OF YOUR PAIN (WITH PERIODS, IN BETWEEN OR WITH INTERCOURSE) EVER KEEP YOU FROM GOING TO WORK, KEEPING A SOCIAL COMMITMENT, OR INTERFERE WITH YOUR ABILITY TO HAVE OR ENJOY INTERCOURSE? NO YES

IF YES, HOW MUCH AND HOW OFTEN _____

SINCE YOUR LAST VISIT, ARE YOUR PELVIC SYMPTOMS:

BETTER WORSE SAME

VAGINAL DISCHARGE? NO YES DESCRIBE: COLOR: _____ ODOR: _____

CONSISTENCY: _____ VISIBLE INFLAMMATION: _____

ITCH: BURN: IRRITATION: OTHER: _____

PROBLEMS FOR WHICH YOU SEE ANOTHER PHYSICIAN _____

ILLNESSES _____

RECENT SURGERY _____

RECENT PREGNANCIES _____

RECENT BONE FRACTURES _____

RECENT TATTOOS OR BLOOD TRANSFUSIONS _____

ANY OTHER SYMPTOMS OR PROBLEMS? _____

LIST ALL CURRENT DRUGS AND THE DOSE
("SAME AS BEFORE" OR "SEE PRIOR LIST" IS NOT ACCEPTABLE)

LIST ALL "HERBAL" DRUGS _____

LIST ALL DRUG ALLERGIES _____

HOW IS YOUR LIBIDO (SEX DRIVE) _____

IF POOR, WHAT DO YOU THINK IS THE CAUSE _____

WHAT IS YOUR CURRENT METHOD OF CONTRACEPTION _____

DO YOU USE "ALTERNATIVE THERAPIES" OR ARE YOU UNDER THE CARE OF AN ALTERNATIVE MEDICINE PRACTITIONER? (ACUPUNCTURE, HOMEOPATHY, NATUROPATHY, CHIROPRACTIC, NUTRITIONAL THERAPY, ETC)
NO YES

IF YES, DESCRIBE _____

NAME _____

GENERAL HEALTH QUESTIONS:

PLEASE CHECK OFF THOSE SYMPTOMS OR OTHER PROBLEMS THAT OCCUR FREQUENTLY OR ARE SEVERE:

HOW WOULD YOU RATE YOUR GENERAL HEALTH _____

	NO	YES
ANY MAJOR CHANGES IN YOUR WEIGHT?	<input type="checkbox"/>	<input type="checkbox"/>
GAINED <input type="checkbox"/> LOST <input type="checkbox"/> HOW MANY LBS _____		
DO YOU FREQUENTLY FEEL NERVOUS OR ANXIOUS	<input type="checkbox"/>	<input type="checkbox"/>
DEPRESSED	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE TROUBLE SLEEPING	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE TROUBLE FALLING ASLEEP	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU WAKE UP IN THE MIDDLE OF THE NIGHT	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE FALLING BACK TO SLEEP	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU FEEL TIRED WHEN YOU WAKE UP	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU TIRED ALL THE TIME	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU TIRE EASILY WITH NORMAL ACTIVITY	<input type="checkbox"/>	<input type="checkbox"/>
TROUBLE CONCENTRATING	<input type="checkbox"/>	<input type="checkbox"/>
MULTIPLE MUSCULAR / JOINT ACHES AND PAINS	<input type="checkbox"/>	<input type="checkbox"/>
GESTATIONAL DIABETES (DIABETES ONLY WHEN PREGNANT) ?	<input type="checkbox"/>	<input type="checkbox"/>
FATIGUE <input type="checkbox"/> WEAKNESS <input type="checkbox"/> FEVER <input type="checkbox"/> NIGHT SWEATS <input type="checkbox"/>		
HEADACHE <input type="checkbox"/> MIGRAINES <input type="checkbox"/> DIZZINESS <input type="checkbox"/> NECK PAIN <input type="checkbox"/>		
NO HEART OR LUNG PROBLEMS <input type="checkbox"/>		
HOARSENESS <input type="checkbox"/> DIFFICULTY IN SWALLOWING <input type="checkbox"/> SINUS PROBLEMS <input type="checkbox"/>		
ALLERGIES <input type="checkbox"/> COUGH <input type="checkbox"/> CHEST PAIN <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/>		
COUGH UP BLOOD <input type="checkbox"/> PALPITATIONS <input type="checkbox"/> RAPID HEART BEAT <input type="checkbox"/>		
ANGINA <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> ACTIVE ASTHMA <input type="checkbox"/> PHLEBITIS <input type="checkbox"/>		
DO YOU HAVE OR IS IT SUSPECTED THAT YOU MIGHT HAVE SLEEP APNEA? NO <input type="checkbox"/>		YES <input type="checkbox"/>

NO INTESTINAL SYMPTOMS

APPETITE CHANGE NAUSEA VOMITING VOMIT BLOOD
FOOD INTOLERANCE BLOAT ULCER GALL BLADDER PROBLEMS
IRRITABLE BOWEL SYNDROME MAJOR CHANGE IN BOWEL HABITS
CONSTIPATION DIARRHEA RECTAL INCONTINENCE
BLOOD IN STOOL PAINFUL BOWEL MOVEMENTS

DO YOU HAVE SHARP STABBING PAINS IN THE RECTUM? VAGINA?
ANY INTESTINAL SYMPTOMS THAT CHANGE WITH MENSTRUAL CYCLE NO YES
IF YES, DESCRIBE _____

SIGMOIDOSCOPY OR COLONOSCOPY? YES NO IF YES, WHEN _____

NO BLADDER OR URINARY SYMPTOMS

HAVING BLADDER PROBLEMS NOW? NO YES
IF SO, DESCRIBE _____

RECENT BLADDER INFECTION? FREQUENT INFECTIONS
KIDNEY INFECTION KIDNEY STONE IF YES, WHAT TYPE _____
KIDNEY X-RAY IF YES, WHAT DID IT SHOW _____

DOES IT BURN WHEN YOU URINATE NO YES
DO YOU URINATE FREQUENTLY NO YES

IF YES, HOW MANY TIMES A DAY? _____

DO YOU OFTEN HAVE THE URGE TO URINATE NO YES
IF YES, IS THERE A LOT TO PASS NO YES

HOW MANY TIMES EACH NIGHT DO YOU HAVE TO GET UP TO URINATE _____

URINARY INCONTINENCE (INVOLUNTARY LOSS OF URINE)? OFTEN

UNDER WHAT CIRCUMSTANCES _____

HAVE YOU NOTICED BLOOD IN YOUR URINE NO YES OFTEN

BLADDER SYMPTOMS THAT VARY WITH MENSTRUAL CYCLE? NO YES

IF YES, DESCRIBE _____

NAME _____

HANDS AND/OR FEET SWELL NO YES WHEN _____

TAKE DIURETICS (WATER PILLS) NO YES HOW OFTEN _____

UNUSUAL SKIN RASHES NO YES IF SO, DESCRIBE _____

ARTHRITIS NO YES WHICH JOINTS _____

LOSS OF HEIGHT OR HUNCHBACKED NO YES

NUMBNESS OR TINGLING NO YES

LEG PAIN WITH WALKING NO YES

BACKACHE: RARE OCCASIONAL FREQUENTLY CONSTANTLY

NO BREAST SYMPTOMS

BREASTS LARGER NO YES BY HOW MUCH _____

BREAST FULLNESS PAIN LUMPS WHERE _____

DO THESE SYMPTOMS VARY WITH YOUR MENSTRUAL CYCLE NO YES

MILK OR FLUID LEAKING FROM YOUR BREASTS NO YES WHICH SIDE _____

WHAT COLOR IS IT _____

DOES IT COME OUT ON ITS OWN OR ONLY IF YOU SQUEEZE _____

LAST MAMMOGRAM _____ **RESULT** _____

ACNE NO YES AGE IT BEGAN _____ STILL ACTIVE NO YES

ANYTIME OR MAINLY WITH PERIOD _____ MAIN LOCATION(S) _____

EXCESS OR COARSE HAIR NO YES AGE IT BEGAN _____

LIST LOCATIONS OF EXCESS HAIR THAT IS A PROBLEM FOR YOU _____

ARE YOU LOSING HAIR NO YES WHERE _____

GOING BALD DEEPER VOICE EASY BRUISING DARK RED STRETCH MARKS

THYROID DISEASE NO YES IF YES, HOW DIAGNOSED _____

UNDERACTIVE OVERACTIVE THYROID CANCER THYROID NODULE

TAKING THYROID HORMONE NOW WHAT DOSE (OR COLOR TABLET) _____

EVER RAPED, ABUSED, OR A BATTERED CHILD, WIFE OR GIRL-FRIEND? NO YES

IF YES, HAVE YOU DEALT WITH IT? _____ HOW _____

DO YOU FEEL COMFORTABLE IN YOUR CURRENT RELATIONSHIP? YES NO

IF NOT, WHY _____

EVER GIVEN RADIATION (X-RAY) TREATMENT FOR ANY REASON? NO YES

(NOT DIAGNOSTIC X-RAYS)

WHY? _____

WHAT PART OF YOUR BODY WAS TREATED? _____

CLOSE FAMILY HISTORY: (PARENTS, SIBLINGS, CHILDREN)

BREAST CANCER? NO YES WHO _____ WHAT AGE _____

UTERINE CANCER? NO YES WHO _____ WHAT AGE _____

OVARIAN CANCER? NO YES WHO _____ WHAT AGE _____

COLON/RECTAL CANCER? NO YES WHO _____

DIABETES? NO YES WHO _____ AGE OF ONSET _____

OSTEOPOROSIS? NO YES WHO _____ AGE OF ONSET _____

ENDOMETRIOSIS? NO YES WHO _____

ANY CLOSE* RELATIVES WITH EARLY HEART DISEASE? (MEN UNDER AGE 55-WOMEN UNDER 65)

* CLOSE = PARENTS, SISTERS OR BROTHERS

NO YES WHO _____

ANY SIGNIFICANT CHANGES IN YOUR PHYSICAL, EMOTIONAL, OR SOCIAL STATUS SINCE YOUR LAST VISIT THAT YOU THINK I SHOULD KNOW ABOUT?

SIGNED _____ DATE _____

WE ARE PROUD TO OFFER A FULL SERVICE MEDSPA WITH A VARIETY OF FDA APPROVED MEDICAL GRADE PRODUCTS AND SERVICES TO TREAT, CORRECT AND PREVENT A RANGE OF SKIN CONDITIONS.

PLEASE INDICATE ANY/ALL SERVICES FOR WHICH YOU WOULD LIKE TO HAVE A FREE CONSULTATION WITH A BREYER MEDSPA REPRESENTATIVE:

- GENERAL SKIN CARE
- SCAR REDUCTION
- VASCULAR THERAPY
- OTHER _____
- LASER HAIR REMOVAL
- SKIN TIGHTENTING/NON-SURGICAL FACE LIFT
- CHEMICAL PEELS
- ACNE TREATMENT
- MICRODERMABRASION
- PIGMENTATION
- SKIN-RESURFACING
- BOTOX/DERMALFILLERS

