## SYMPTOM CHECKLIST

**Please indicate how often you have the following**

| | | | |
|---|---|---|---|
| **Night sweats:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Hot Flashes / Hot Flushes:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Pain with intercourse:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Vaginal Dryness:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Sleeping Problems:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Urine leaks when you cough or sneeze:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Difficulty concentrating:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Mood swings:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Migraines:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Depression:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Anxiety:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Decrease in sexual desire:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Decrease in energy level:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Loss of memory:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Foggy thinking:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |
| **Muscle and/or joint pain:** | ☐ **Frequently** | ☐ **Rarely** | ☐ **Never** |

**Please check the boxes below if they apply to how you have dealt with the above symptoms**

**Herbal medications / supplements** ☐ **YES** ☐ **NO**
**Please specify how:**

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**Change of diet:** ☐ **YES** ☐ **NO**
**Please specify how:**

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**Layered clothing:** ☐ **YES** ☐ **NO**
**Please specify how:**

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**Increase exercise:** ☐ **YES** ☐ **NO**
**Please specify how:**

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**Other:**

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## GYN HISTORY

**Are you sexually active:** ☐ YES ☐ NO
**Have you been sexually active:** ☐ YES ☐ NO
**Do you have pain with intercourse:** ☐ YES ☐ NO
**What type of contraception are you currently using (Please check all that apply):**

☐ Pills ☐ IUD ☐ Foam ☐ Condoms
☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal
☐ Implants ☐ Depo Shot ☐ Provera
☐ Other

**What type of contraception have you used in the past (Please check all that apply):**

☐ Pills ☐ IUD ☐ Foam ☐ Condoms
☐ Tubal Ligation ☐ Vasectomy ☐ Diaphragm ☐ Withdrawal
☐ Implants ☐ Depo Shot ☐ Provera
☐ Other

**Are you having any problems with your method of birth control?** ☐ YES ☐ NO
**Have you ever had any vaginal, cervical and/or tubal infection?** ☐ YES ☐ NO
**If yes, please check below all that apply:**

☐ Gardnerella ☐ Syphilis ☐ Condyloma ☐ Bacterial Vaginitis
☐ Yeast ☐ PID ☐ Chlamydia
☐ Herpes ☐ Gonorrhea ☐ Warts
☐ Other_____

**Date of last pap smear:** _____
**Have you ever had an abnormal pap smear?** ☐ YES ☐ NO
**If yes, how was it treated (please check all that apply):**

☐ Repeated pap ☐ Colposcopy ☐ Laser surgery ☐ Cone Biopsy
☐ Cryosurgery ☐ Hysterectomy ☐ Loop Excition

**Have you ever had cervical cancer:** ☐ YES ☐ NO
**If yes, how was it treated:**_____
**Have you ever had uterine cancer:** ☐ YES ☐ NO
**If yes, how was it treated:**_____
**Do you have trouble leaking urine:** ☐ YES ☐ NO
**Do you have any breast lumps, tenderness or discharge:** ☐ YES ☐ NO
**Have you ever had a mammogram:** ☐ YES ☐ NO
**If yes, was it normal:** ☐ YES ☐ NO
**Date of last mammogram:** _____
**Do you do self breast exams:** ☐ YES ☐ NO
**Do you have PMS symptoms:** ☐ YES ☐ NO
**If yes, are you undergoing treatment:** ☐ YES ☐ NO
**If yes, what type of treatment:** _____
**Do you have any uterine abnormality:** ☐ YES ☐ NO
**Do you have a history of infertility:** ☐ YES ☐ NO
**Do you have a history of DES exposure:** ☐ YES ☐ NO
**Do you have fibroids of the uterus:** ☐ YES ☐ NO
**Have you had abnormal bleeding in the past year:** ☐ YES ☐ NO
**If yes, please describe:**_____
_____
_____
_____

**At what age did you start menopause:**

## MENSTRUAL HISTORY

**If you no longer have periods, please check the reason:**

☐ **Natural** ☐ **Hysterectomy** ☐ **Ablation** ☐ **Menopause**

**Do you have a uterus** ☐ **YES** ☐ **NO**

**First day of last period:** _____

**Typically, how many days does your period last:** _____

**Are your periods regular:** ☐ **YES** ☐ **NO**

**How many days are between the start of your periods:** _____

**Has the flow of your period changed in any way:** ☐ **YES** ☐ **NO**

**If yes, please explain the change:** _____

**Does bleeding occur between your normal period** ☐ **YES** ☐ **NO**

**Do you suffer from cramps during your periods** ☐ **YES** ☐ **NO**

**If yes, please check the pain associated with the cramps**

☐ **Mild** ☐ **Moderate** ☐ **Severe**

**What medicine, if any, are you currently taking for your cramps:**

_____

## SOCIAL HISTORY

**Do you smoke cigarettes:** ☐ **YES** ☐ **NO**

**If yes, how many do you smoke per day:** _____

**Please list the number of years you have been smoking:** _____

**Do you use recreational drugs:** ☐ **YES** ☐ **NO**

**Do you drink alcohol:** ☐ **YES** ☐ **NO**

**If yes, what type of alcohol do you drink:** _____

**How many drinks per week, on average, do you drink:** _____

**Are you using any form of Testosterone or Hormone Therapy:** ☐ **YES** ☐ **NO**

**If yes, please check which type:**

☐ **Gel** ☐ **Cream** ☐ **Shots** ☐ **Pellets** ☐ **Other**

## MEDICAL HISTORY

**Do you have diabetes:** ☐ **YES** ☐ **NO**

**Do you have or have you ever had hypertension:** ☐ **YES** ☐ **NO**

**Do you have heart disease:** ☐ **YES** ☐ **NO**

**Have you ever had a heart attack:** ☐ **YES** ☐ **NO**

**Have you ever had a stroke:** ☐ **YES** ☐ **NO**

**Do you have a heart murmur:** ☐ **YES** ☐ **NO**

**Do you have or have you ever had kidney disease:** ☐ **YES** ☐ **NO**

**Have you ever been treated for a psychiatric disorder:** ☐ **YES** ☐ **NO**

**If yes, please name the disorder:** _____

**Have you ever had rheumatic fever:** ☐ **YES** ☐ **NO**

**Do you have mitral valve prolapsed:** ☐ **YES** ☐ **NO**

**Have you ever had a urinary tract infection:** ☐ **YES** ☐ **NO**

**Have you ever had hepatitis** ☐ **YES** ☐ **NO**

**If yes, please check which type:**

☐ **Hepatitis A** ☐ **Hepatitis B** ☐ **Hepatitis C** ☐ **Other**

**Have you ever had liver disease:** ☐ **YES** ☐ **NO**

**Have you ever had varicose veins:** ☐ **YES** ☐ **NO**

**Have you ever had phlebitis:** ☐ **YES** ☐ **NO**

**Do you have any thyroid problems:** ☐ **YES** ☐ **NO**

**If yes, please check the problem:**

☐ **Low Function** ☐ **Overactive** ☐ **Goiter** ☐ **Hashimoto's**

**Have you ever had a blood transfusion:** ☐ **YES** ☐ **NO**

**Do you have asthma, emphysema, or chronic bronchitis:** ☐ **YES** ☐ **NO**
**Do you or have you ever had leukemia:** ☐ **YES** ☐ **NO**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Please check the type of treatment:** ☐ **Surgery** ☐ **Radiation**
**Do you or have you ever had lymphoma:** ☐ **YES** ☐ **NO**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Please check the type of treatment:** ☐ **Surgery** ☐ **Radiation**
**Do you or have you ever had colon cancer:** ☐ **YES** ☐ **NO**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Pease check the type of treatment:** ☐ **Surgery** ☐ **Radiation**
**Do you or have you ever had colon plyps:** ☐ **YES** ☐ **NO**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Do you or have you ever had multiple myeloma:** ☐ **YES** ☐ **NO**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Do you or have you ever had lung cancer:** ☐ **YES** ☐ **NO**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Do you or have you ever had rectal cancer:** ☐ **Surgery** ☐ **Radiation**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Please check the type of treatment:** ☐ **YES** ☐ **NO**
**Do you or have you ever had breast cancer:** ☐ **YES** ☐ **NO**
**If yes, are you currently undergoing any treatment:** ☐ **YES** ☐ **NO**
**Please check the type of treatment:**
☐ **Lumpectomy** ☐ **Mastectomy** ☐ **Radiation** ☐ **Chemotherapy**
**Please list all the drug allergies you have:**

**Please list all the major surgeries you have had (including year and reason):**

**Please list any other operations/hospitalizations you have received (including year and reason):**

**Have you ever had any anesthesia complications:** ☐ **YES** ☐ **NO**
**If yes, please explain:**

**Are you currently or have you ever been anemic:** ☐ **YES** ☐ **NO**
**Do you have an Internist or Family Physician:** ☐ **YES** ☐ **NO**
**Please list the name of the physician and number where they may be reached:**
**Name:** **Phone Number:**
**Are you currently taking any medications:** ☐ **YES** ☐ **NO**
**Please list the medications you are currently taking as well as the dosage:**

**Have you ever had your cholesterol checked:** ☐ **YES** ☐ **NO**
**If yes, what was the date it was last checked:**
**How was your cholesterol:** ☐ **Low** ☐ **Normal** ☐ **High**
**Do you have arthritis:** ☐ **YES** ☐ **NO**
**If yes, what type**
**Do you have lupus:** ☐ **YES** ☐ **NO**
**Do you have scleroderma:** ☐ **YES** ☐ **NO**
**Do you have blood clots in your legs or lungs:** ☐ **YES** ☐ **NO**
**Do you have problems with water retention:** ☐ **YES** ☐ **NO**
**Do you have problems with swelling:** ☐ **YES** ☐ **NO**
**Do you have problems with bloating:** ☐ **YES** ☐ **NO**

**Do you have osteoporosis:** ☐ **YES** ☐ **NO**
**If yes, how was it treated:**_____
**Do you have osteoporosis:** ☐ **YES** ☐ **NO**
**If yes, how was it treated:**_____
**Do you suffer from hair loss:** ☐ **YES** ☐ **NO**
**Do you suffer from or have you had acne:** ☐ **YES** ☐ **NO**

## FAMILY HISTORY

**Do you have a family history of breast cancer:** ☐ **YES** ☐ **NO**
**Who:** _____
**Do you have a family history of colon cancer:** ☐ **YES** ☐ **NO**
**Who:** _____
**Do you have a family history of ovarian cancer:** ☐ **YES** ☐ **NO**
**Who:** _____
**Do you have a family history of osteoporosis:** ☐ **YES** ☐ **NO**
**Who:** _____
**Do you have a family history of diabetes:** ☐ **YES** ☐ **NO**
**Who:** _____
**Do you have a family history of hypertension:** ☐ **YES** ☐ **NO**
**Who:** _____
**Do you have a family history of heart disease:** ☐ **YES** ☐ **NO**
**Who:** _____
**Do you have a family history of kidney disease:** ☐ **YES** ☐ **NO**
**Who:** _____
**At what age did your mother go through menopause:**

# BEVERLY MEDICAL CENTER

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**Mammogram Waiver for Hormone Therapy**
**Which May Include Testosterone Pellet Therapy**

I, _____, voluntarily choose to undergo bio-identical hormone therapy, which
(Patient Name)

may include implantation of subcutaneous testosterone pellet therapy, with _____.
(Treating Provider)

For today's appointment, I **do not** have a Mammogram Report for this reason:

☐ My decision not to have one.

☐ My doctors decision to not have one, Dr. _____. Please provide a note from the aforementioned physician outlining the rationale.

☐ Unable to provide report at this time.

| |
|---|
| Mammogram report information: |
| Date of Mammogram report: _____ |
| My results were: ☐ Normal ☐Abnormal |

I am aware that a current report must be sent by mail or faxed to our office prior to my next HRT appointment. The Treating Provider has discussed the importance and necessity of a mammogram since I receive hormones. _____ (Patient Initials)

I understand that mammograms are the best single method for detection of early breast cancer. I understand that my refusal to submit to a mammogram test may result in cancer remaining undetected within my body. I acknowledge that I bear full responsibility for any personal injury of illness, accident, risk or loss (including death and/or breast or uterine issues) that may be sustained by me in connection with my decision to refrain from obtaining a mammogram exam. I acknowledge and agree that I have been given adequate opportunity to review this document and to ask questions. I hereby release and agree to hold harmless Treating Providers and Beverly Medical Center's physicians, nurses, officers, directors, employees and agents from any and all liability, claims demands and actions arising or related to any loss, property damage, illness, injury or accident that may be sustained by me as a result of my refusal to undergo a mammogram exam. This release and hold harmless agreement is and shall be binding on myself and heirs, assigns and personal representatives.

_____ _____
Patient Signature Date

_____ _____
Treating Provider Signature Date