ORTHORITY 360™
TOTAL BODY WELLNESS

INTAKE & HISTORY — FEMALE
PATIENT QUESTIONNAIRE

TODAY'S DATE

CLIENT NAME			DATE OF BIRTH	
STREET ADDRESS I APT #	CITY		STATE	ZIP
HOME PHONE	CELL PHONE	WORK PHONE		
EMAIL ADDRESS		MARITAL STATUS ◯ SINGLE ◯ MARRIED		
WEIGHT	OCCUPATION			

IN CASE OF EMERGENCY, PLEASE NOTIFY:

NAME		RELATIONSHIP
HOME PHONE	CELL PHONE	WORK PHONE

PRIMARY CARE PHYSICIAN

NAME		PHONE	
STREET ADDRESS I APT #	CITY	STATE	ZIP

In the event we cannot contact you by the mean's you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below, you are giving us permission to speak with your spouse or significant other about your treatment.

NAME		RELATIONSHIP
HOME PHONE	CELL PHONE	WORK PHONE

HABITS

I SMOKE ◯ CIGARETTES ◯ CIGARS _____ PER DAY	I DRINK ALCOHOLIC BEVERAGES _____ PER WEEK
I DRINK MORE THAN 10 ALCOHOLIC BEVERAGES ◯ PER WEEK ◯ PER DAY	I USE CAFFEINE _____ PER DAY

SOCIAL

◯ I AM SEXUALLY ACTIVE	◯ I HAVE COMPLETED MY FAMILY
◯ I WANT TO BE SEXUALLY ACTIVE	◯ I HAVE USED STEROIDS IN THE PAST FOR ATHLETIC PURPOSES

MEDICAL HISTORY

ANY KNOWN DRUG ALLERGIES?	HAVE YOU EVER HAD ISSUES WITH ANESTHESIA? ◯ YES ◯ NO
MEDICATIONS CURRENTLY BEING TAKEN	
CURRENT HORMONE REPLACEMENT THERAPY	PAST HORMONE REPLACEMENT THERAPY
NUTRITIONAL VITAMINS/SUPPLEMENTS	
SURGERIES (LIST ALL AND APPROXIMATE DATE)	
LAST MENSTRUAL PERIOD (ESTIMATE YEAR IF UNCERTAIN)	

ADDITIONAL PERTINENT INFORMATION

PREVENTATIVE MEDICAL CARE

◯ MEDICAL/GYN EXAM IN THE LAST 12 MONTHS ◯ MAMMOGRAM IN THE LAST 12 MONTHS
◯ BONE DENSITY IN THE LAST 12 MONTHS ◯ PELVIS ULTRASOUND IN THE LAST 12 MONTHS

HIGH RISK PAST MEDICAL/SURGICAL HISTORY

◯ BREAST CANCER ◯ UTERINE CANCER ◯ OVARIAN CANCER ◯ HYSTERECTOMY
◯ HYSTERECTOMY WITH REMOVAL OF OVARIES ◯ OOPHORECTOMY (REMOVAL OF OVARIES)

BIRTH CONTROL METHOD

◯ MENOPAUSE ◯ HYSTERECTOMY ◯ TUBAL LIGATION ◯ BIRTH CONTROL PILLS ◯ VASECTOMY
◯ OTHER:

MEDICAL ILLNESSES

◯ HIGH BLOOD PRESSURE ◯ HEART BYPASS ◯ HIGH CHOLESTEROL ◯ HYPERTENSION ◯ HEART DISEASE
◯ STROKE AND/OR HEART ATTACK ◯ BLOOD CLOT AND/OR PULMONARY EMBOLISM ◯ ANY FORM OF HEPATITIS OR HIV ◯ LUPUS OR OTHER AUTOIMMUNE DISEASE ◯ FIBROMYALGIA
◯ ARRHYTHMIA ◯ DIABETES ◯ THYROID DISEASE ◯ TROUBLE PASSING URINE OR TAKE FLOMAX/AVODART
◯ ARTHRITIS ◯ DEPRESSION/ANXIETY ◯ PSYCHIATRIC DISORDER ◯ CHRONIC LIVER DISEASE (HEPATITIS, FATTY LIVER, CIRRHOSIS

◯ CANCER: (TYPE) _____ YEAR _____

SIGNATURE	DATE