PRE-TREATMENT HISTORY (female)

Last name: _____**First name:** _____ Age: _____

Preferred to be addressed as (name):_____ Date of Birth: ____/____/_____

Address: _____ Zip Code_____

Phones Home: (___)____-_____Work: (___)____-_____Mobile:(___)____-_____

Occupation: _____Weight _____ Height _____

E-mail Address_____

Primary Physician: Name_____ Phone: (___) ____-_____

Address:_____

Please list and rate (on a scale from 1 (best) to 10 (worst) your 5 top symptoms as indications for treatment:

	Symptoms	Rate
1).	_____	_____
2).	_____	_____
3).	_____	_____
4).	_____	_____
5).	_____	_____

Are you pregnant (possibly)? Date of the last menstrual period _____

Any other symptoms you experience, which are not listed: _____

How would you rate your nutrition?_____

Past medical history:

Please circle if you were diagnosed with any of these:

Heart disease/Heart attack High Blood Pressure Lipid disorder Blood clots

Stroke Seizures Headache Glaucoma Thyroid disease Osteoporosis/Weak bones

Lung disease Shortness of breath Asthma Emphysema Diabetes Immune disorder

Hepatitis/Intestinal problems Kidney disease HIV/AIDS Blood disorder Cancer Chemical dependency

Family History: please list your parents' health problems

Father_____

_____

Mother_____

_____

Others (not listed)_____

Have you ever had any unexpected local anesthesia problems? _____

Have you ever been under the care of a psychiatrist? _____

Are you involved in any litigation? Describe_____

Surgical History:

Please list your surgeries:_____

_____

_____

Allergies: _____

_____

Adverse reaction to the medication(s)(if any)_____

Medications : (currently taken)_____

_____

_____

Supplements : (currently taken)_____

_____

_____

Social History:

Do you exercise? _____ How many times per week?_____

Do you smoke/if yes, how much?_____ Alcohol ?, how much?_____

Are you currently seeing any of the following:

Pain Specialist	Name_____	Telephone_____
Weight Management	Name_____	Telephone_____
Chiropractor	Name_____	Telephone_____

Is the above information true and complete? YES or NO

Signature_____ Date:_____

4011 Richmond Ave Houston, TX 77027
Tel: 713-661-9995 Fax: 713-669-1380

I_____ understand the continuing need for routine medical screening including pap smear/mammogram. I give permission for John Share, D.O. to begin/continue Bio-Identical Hormone Replacement therapy even though I have not provided documentation or record of a pap smear/ mammogram in the past year. I understand it is my responsibility to provide these medical records. I release MyVita Wellness Institute, employees/staff and/or John Share, D.O. of any malpractice related to hormone therapy.

Patient Signature:_____ Date:_____

Notes:

_____
_____
_____
_____
_____