JW • HOLLAND
WELLNESS

NEW PATIENT QUESTIONNAIRE

Name:_____ Today's Date:_____

(Last) (First) (Middle Initial)

Date of Birth:_____ Age:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work:_____

Email Address:_____

How did you hear about us? Patient Name:_____ Other:_____

In Case of Emergency Contact:_____ Relationship:_____

Cell Phone:_____ Home Phone:_____ Work:_____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? ☐Electronic ☐Paper

MEDICAL HISTORY

Height:_____ Weight:_____ Last Menstrual Period:_____ Hysterectomy? ( ) No ( ) Partial ( ) Full

Do you smoke? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Do you drink alcohol? ( ) Yes ( ) No ( ) Quit How much?_____ How often?_____ Age started?_____

Any known drug allergies: ( ) Yes ( ) No If yes please explain:_____

Current Medications and dosage:_____

_____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy:_____ Past HRT: _____

Surgeries, list all and Year:_____

Other Pertinent Information: _____

_____ _____ _____

PRINT NAME SIGNATURE DATE

Do you have a personal history of? Check all that apply.

Preventative Medical Care:

( ) Medical/GYN Exam in the last year

( ) Mammogram in the last 12 months

( ) Bone Density in the last 12 months

( ) Pelvic ultrasound in the last 12 months

High Risk Past Medical/Surgical History:

( ) Breast Cancer

( ) Uterine Cancer

( ) Ovarian Cancer

( ) Hysterectomy with removal of ovaries

( ) Hysterectomy only

( ) 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 a pulmonary emboli

( ) Arrhythmia

( ) Any form of Hepatitis or HIV

( ) Lupus or other auto immune disease

( ) Fibromyalgia

( ) Trouble passing urine or take Flomax or Avodart

( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)

( ) Diabetes

( ) Thyroid disease

( ) Arthritis

( ) Depression/anxiety

( ) Psychiatric Disorder

( ) Cancer Type:_____Year: _____