THE

iBODY

956 Huntington Drive
San Marino, CA 91108
Phone: 626.593.5993

Patient Name:____ DOB: __________________

Please Answer All Questions Below

Have you had a hysterectomy? ___Y ___N ________Date When was your last period? ___________

Have you been on Hormone Replacement Therapy (HRT)? ___Y ___N

If YES, how long have you been on HRT? ____

If YES, what did you take and how often? ____

Do you have bleeding in between periods? ___Y ___N Are you sexually active? ___Y ___N

Do you have Breast Lump(s)? ___Y ___N Do you have Nipple Discharge? ___Y ___N

Please provide the date for the following tests:

Mammogram: ________________________ Normal ____ Abnormal ____

Pap Smear: __________________________ Normal ____ Abnormal ____

Bone Density: ________________________ Normal ____ Abnormal ____

Please check all disease(s) that apply to you: ____Breast Cancer ____Fibroid Tumors ____Endometriosis ____Fibrocystic Breast Disease ____Fibromyalgia ____Depression

FAMILY HISTORY (Parents & Siblings)

Alcoholism ___Who _______________

Alzheimer's Disease ___Who _______________

Breast Cancer ___Who _______________

Diabetes ___Who _______________

Heart Disease ___Who _______________

Hypertension ___Who _______________

Osteoporosis ___Who _______________

Ovarian Cancer ___Who _______________

Thyroid Disease ___Who _______________

Uterine Cancer ___Who _______________

Have you experienced any of the following symptoms recently?

Symptoms	**Yes/Duration**	**No**	**Symptoms**	**Yes/Duration**	**No**
Sleep Disturbance			Decreased Sex Drive		
Fatigue			Breast Tenderness		
Weight Gain			Heavy Period		
Hot Flushes/sweat			Headache		
Irritability			Mood Swing		
Anxiety			Hair Loss		
Depression			Joint Pain		
Memory Loss			Loss of Interest		
Mental Fog			Vaginal Dryness		
Dry Skin			Painful Intercourse		
Bladder Symptoms			Hard to Reach Climax		

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Patient Signature Date