

Patient Intake Form

Women’s Health-Endocrine

Dr. Theo Christodoulakis, Along with the General Intake Form

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Name: _____ **Age:** _____ **Date:** _____ **Race:** _____
Age of first menstruation: _____ **Age/Date last menstruation:** _____
Are you on Hormonal Therapy (HRT)? _____ **Type/when:** _____
Ever been on Hormonal Therapy? _____ **Ever had been on HRT?** _____
Are you on Thyroid Medication? _____ **Type/When:** _____

Instructions:

Please check all the symptoms that apply to you (even if there are duplicated)

Use numbers 1-3 (3 is worst) for symptoms that bother you the most.

EE

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| Mood Swings | <input type="checkbox"/> | Fibrocystic Breasts | <input type="checkbox"/> |
| Tender Breasts | <input type="checkbox"/> | (cyclic pain/tenderness or nodules) | |
| Water Retention | <input type="checkbox"/> | Weight gain (around Hips & Thighs) | <input type="checkbox"/> |
| Nervousness/Irritability | <input type="checkbox"/> | Low libido (low sex drive) | <input type="checkbox"/> |

ED

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|---------------------|--------------------------|------------------------|--------------------------|
| Hot Flashes | <input type="checkbox"/> | Heart palpitations | <input type="checkbox"/> |
| Night sweats | <input type="checkbox"/> | Sleep disturbances | <input type="checkbox"/> |
| Vaginal dryness | <input type="checkbox"/> | Bone Loss | <input type="checkbox"/> |
| Painful intercourse | <input type="checkbox"/> | Dry skin/Hair | <input type="checkbox"/> |
| Memory lapses | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Incontinence | <input type="checkbox"/> | Vph > 4.5 doctor’s use | |

PD

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|-----------------------|--------------------------|--------------------|--------------------------|
| Fluid/Water Retention | <input type="checkbox"/> | Sleep Disturbances | <input type="checkbox"/> |
| Anxiety | <input type="checkbox"/> | Bone Loss | <input type="checkbox"/> |
| Heavy Periods | <input type="checkbox"/> | Dry Skin/Hair | <input type="checkbox"/> |
| Irritability | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Heart Palpitations | <input type="checkbox"/> | | |

PE

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|-----------|--------------------------|------------|--------------------------|
| Dizziness | <input type="checkbox"/> | Sleepiness | <input type="checkbox"/> |
|-----------|--------------------------|------------|--------------------------|

TD

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|---------------------|--------------------------|-------------------|--------------------------|
| Weakness | <input type="checkbox"/> | Constipation | <input type="checkbox"/> |
| Sweating | <input type="checkbox"/> | Loose stools | <input type="checkbox"/> |
| Weight loss | <input type="checkbox"/> | Irritability | <input type="checkbox"/> |
| Weight Gain | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> |
| Nervousness/anxiety | <input type="checkbox"/> | Leg/Arms Swelling | <input type="checkbox"/> |
| Feeling cold | <input type="checkbox"/> | Dry Nails | <input type="checkbox"/> |
| Feeling Hot | <input type="checkbox"/> | Hair Loss | <input type="checkbox"/> |

Female General Intake Form

Dr. Theo Christodoulakis

Name: _____ **Age:** _____ **Date:** _____ **Race:** _____

Age of first menstruation: _____ Age/Date last menstruation: _____

Cycle: regular: _____ irregular: _____ length of menses: _____ notes: _____

Any concerns with your cycle: _____

Do you use pads or tampons: _____ # pads/tampons per day: _____ color/clots: _____/_____

Hx of irregular pap smears: _____ Hx of STD's: _____ Family Hx of cancer: _____

Bone density scan: _____ Last mammogram/findings: _____ Hx of surgeries: _____

Last Gynecological exam: _____ Any abnormalities: _____

PMS:

Breast tenderness: _____ bloating: _____ irritability: _____ Head-aches: _____ pain: _____ cravings: _____

Severity of PMS (0-3, 3 is worst): _____ PMS before, during or after menses: _____

Type of contraception used: _____ satisfied? _____

Caffeine consumption: _____/day Alcohol consumption: _____ Chocolate per day: _____

Do you have any of the following?

Excessive body hair? _____ Over-Weight? _____ Height/Weight: _____

History of Diabetes: _____ Stress incont.: _____ Pelvic pain: _____

Frequent Urinary track infections? _____ How many per year ? _____ Frequent colds: _____

Vaginal discharge: _____ Vaginal itching: _____ Vaginal odor (strong foul): _____ onset: _____

Pain during urination: _____ Pain during intercourse: _____ Back pain Chronic or acute: _____

History of Depression: _____ History of Thyroid disease: _____ Hx of Mental illness: _____

Any other female concerns: _____

Doctor Notes During Exam:

BP: _____ Pulse: _____ HR: _____ Weight: _____ Appearance (Shen): _____