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EMAIL ADDRESS_____

NAME:_____ REFERRED BY:_____ DATE:_____

ADDRESS_____PHONE( )_____

DATE OF BIRTH:_____ AGE:_____ OCCUPATION:_____

HEALTH HABITS: (PLEASE CIRCLE) **CAFFEINE TOBACCO ALCOHOL RECREATIONAL DRUGS**

WHAT WAS THE FIRST DAY OF YOUR LAST PERIOD? _____

ARE YOU ON ANY TYPE OF BIRTH CONTROL? **YES** **NO**
IF YES, WHAT TYPE?

_____

ARE YOU POST MENOPAUSAL? **YES** **NO**
IF YES, HOW LONG HAVE YOU BEEN POST MENOPAUSAL?

_____

ARE YOU CURRENTLY TAKING ANY HORMONE REPLACEMENT THERAPY? **YES** **NO**
IF YES, WHAT KIND?

_____

DO YOU HAVE ANY ALLERGIES? **YES** **NO**
IS YES, WHAT ARE THEY?

_____

DO YOU HAVE ANY CHRONIC ILLNESS? **YES** **NO**
IF YES WHAT TYPE?

_____

PLEASE LIST ANY HOSPITALIZATIONS/SURGIES: (REASON, TYPE OF SURGERY, DATE)

_____

_____

HAVE YOU TAKEN ANY IBUPROFEN, MOTRIN, NAPROXEN, VITAMIN E, OR BLOOD THINNERS IN THE LAST 72 HOURS? **YES** **NO**
PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

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