VITALITY HEALTH
302-643-2500

PATIENT INFORMATION - FEMALE BIOTE		
Name:		Date of Birth:
Address:		**City:**
State / Zip		
Cell Phone		**SSN**
Email Address (Required to access patient portal):		
Gender		**Married Single Widowed Divorced**
Ethnicity	**Not Hispanic or Latino**	**Hispanic or Latino**
Race	White Black or African American	Native American Asian Other
PREFERRED PHARMACY		
Pharmacy Name		Phone:
Pharmacy Address		
INSURANCE INFORMATION		
Insurance Co Name		
Policy No		GROUP:
RESPONSIBLE PARTY		
Card Holder Name		DOB
SSN		
Address		
City		State/Zip
Phone		Cell Phone
Relationship to Patient	Spouse Child of Card Holder	
SECONDARY INSURANCE		
Insurance Co Name		
Policy		Group No
Guarantor Name		Date of Birth
EMERGENCY CONTACT		
Cell Phone		
PRIMARY PHYSICIAN INFORMATION		
Name		
Address		
Phone		Fax

MEDICATIONS

Please List All Medications & Dosages. Include Birth Control Pills, Over-The Counter Medicines, Herbals, And Vitamins.

MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBED BY AND REASON

ADULT HEALTH HISTORY

Have you been diagnosed with any of the following:

	Diabetes		Arthritis		Anxiety
	Hypothyroidism		Osteoporosis		Bipolar
	High Blood Pressure		COPD		Cancer
	High Cholesterol		Asthma		Kidney disease
	Stroke		Lupus		Liver disease (Hepatitis)
	Heart attack		Migraines		
	Heart Arrhythmia (Afib)		Seizures		
	Blood clots (Leg, Arm, Lung)		Depression		

DO YOU HAVE ANY ALLERGIES _____

SURGICAL HISTORY

Date	Details

FAMILY HISTORY

☐ I WAS ADOPTED

Family Member	Alive/Deceased	Age/Age at death	Illness
Father			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Mother			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Siblings			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke
Children			Diabetes Heart Disease High Cholesterol Cancer : Type_____ Hypertension Stroke

SOCIAL HISTORY

MARITAL STATUS ☐ M ☐ S ☐ D ☐ W PARTNER	ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO ☐ MEN ☐ WOMEN ☐ BOTH ☐ PREVIOUSLY NOT NOW
DRINK ALCHOHOL ☐ YES ☐ NO ☐ FORMER HOW MANY DRINKS/WEEK	DO YOU EXERCISE ☐ YES ☐ NO
DO YOU SMOKE ☐ NO ☐ CURRENT SMOKER HOW MANY CIG/DAY_____ FOR _____ YEARS	☐ FORMER SMOKER HOW MANY CIG/DAY_____ FOR _____ YEARS
HAVE YOU USED ANY IN THE LAST YEAR? ☐ MARIJUANA ☐ HEROIN ☐ COCAINE ☐ OTHER	DO YOU USE ANY OTHER SUBSTANCES? ☐ YES ☐ NO IF YES, WHAT TYPE _____

HEALTH SCREENINGS

Have you ever had a Bone Density/DEXA? ☐ Yes ☐ No

Month/Year of last Bone Density/DEXA? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain: _____

Have you ever had a colonoscopy? ☐ Yes ☐ No

Month/Year of last colonoscopy? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain:_____

Have you ever had a Cholesterol test? ☐ Yes ☐ No

Have you ever been tested for diabetes? ☐ YES ☐ NO

Month/year of last Diabetes test? _____Result ☐ Normal ☐ Abnormal

If abnormal, please explain _____

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MENSTRUAL & ANNUAL EXAM HISTORY

Age Of First Menstrual Period	Do You Currently Have Menstrual Periods? ☐ Yes Date Of The First Day Of Your Last Period? _____ ☐ No What Year Was Your Last Period? _____
Are Your Periods Regular? ☐ Yes ☐ No If No, Please Explain:	☐ Never Had An Annual Exam Month/Day/Year Of Last Annual Exam: _____ Result ☐ Normal ☐ Abnormal
Have You Ever Had Abnormal Pap? ☐ Yes ☐ No In What Year_____	List Treatment (If Any)
Date Of Last Mammogram _____ ☐ Never Had A Mammogram	Result ☐ Normal ☐ Abnormal If Abnormal, Please Explain _____ Do You Perform Self Exams? ☐ Yes ☐ No
Number Pregnancies	Total Living Children
# Of Full Term Deliveries	# Of Abortions
# Of Miscarriages	# Of Etopic Pregnancies
Number Of C-Sections	

How did you hear about us? _____

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Women's Hormone Health Questionnaire

SYMPTOMS	NONE	MILD	MODERATE	SEVERE
Physical Exhaustions (fatigue, lack of energy, stamina, or motivation				
Sleep Problems (difficulty falling asleep or sleeping through the night)				
Irritability (mood swings, feeling aggressive, angers easily)				
Anxiety (Feeling overwhelmed, feeling panicky, or feeling nervous)				
Decline in drive or inters (loss of 'zest for life', feeling down or sad				
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)				
Difficulties with memory (concentration, finding the right word, or retaining information)				
Vaginal Dryness or difficulty with sexual intercourse				
Sexual problems (Change in desire, activity, orgasm and/or satisfaction)				
Sweating (night sweats or increased episodes of sweating)				
Hot Flashes (burst that starts in chest and lasts for short duration)				
Hair loss, thinning or change in texture of hair				
Feeling cold all the time, having cold hands or feet				
Headaches or migraines (increase in frequency or intensity)				
Weight (difficulty losing weight despite diet/exercise)				
Bladder problems (difficulty in urinating, increased need to urinate, incontinence				

How did you hear about us? _____