

COLEMAN PRIMARY CARE
SOTTOPELLE
FEMALE QUESTIONNAIRE & CHECK LIST

NAME: _____ DOB: _____

HEIGHT: _____ WEIGHT: _____ RACE: _____

OF PREGNANCIES: _____ # OF LIVE BIRTHS: _____ # OF MISCARRIAGES/ABORTIONS: _____

CURRENT MEDICATIONS: _____

CURRENT NON-PELLET ESTRADIOL DOSE & FORM: _____

ALLERGIES: _____

PREVIOUS ESTRADIOL DOSE (RETURNING PTS): _____

HISTORY OF RENAL DISEASE: YES NO

ACTIVE LIVER DISEASE: YES NO

HYSTERECTOMY: YES NO

HISTORY OF CERVICAL CANCER: YES NO

HISTORY OF OVARIAN CANCER: YES NO

FIBROCYSTIC BREAST DISEASE: YES NO

HISTORY OF BREAST CANCER: YES NO

ACNE: YES NO

FACIAL HAIR: YES NO

HAIR LOSS: YES NO

HISTORY OF PCOS: YES NO

HISTORY OF HEAVY MENSES YES NO

HISTORY OF METABOLIC SYNDROME YES NO

PLEASE FORWARD THIS FORM ALONG WITH THE FOLLOWING INFORMATION PRIOR TO YOUR
APPOINTMENT:

_____ BLOODWORK RESULTS (INC. HEMOGLOBIN A1C FOR DIABETIC PTS)

_____ MAMMOGRAM (MUST BE WITHIN THE LAST YEAR)

_____ MOST RECENT PAP SMEAR

_____ CURRENT PHYSICAL

_____ BONE DENSITY (IF YOU'RE AGE 40 OR OLDER)

