



Patient Name _____

Female Patient Questionnaire & History

PATIENT INFORMATION

Name: _____ Date: _____
Birth Date: _____ Age: _____ Weight: _____ lbs Height: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Mobile Phone: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____
How did you hear about us? _____
Preferred Pharmacy: _____ Phone: _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____

Would you like to authorize Sozo Integrative Health to have permission to speak to the individual named below about your treatment? By giving the information below you are giving us permission to speak with the individual about your treatment.

Name: _____ Relationship: _____ Phone: _____

MEDICATIONS/ MEDICATION ALLERGIES

Drug Allergies: _____

Current Medications & Dose:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Supplements:

_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Sexually Active ☐ Yes ☐ No I have completed my family ☐ Yes ☐ No

Current Method of Birth Control _____

Current/Past Hormone Replacement Therapy ☐ Yes ☐ No If Yes, What? _____

MENSTRUAL HISTORY

Age of Onset: _____ Last Pap smear: _____ Last Mammogram: _____
 Irregular/Heavy Periods ☐ No ☐ Yes Uterine Fibroids ☐ No ☐ Yes
 Cramps ☐ No ☐ Yes Infertility ☐ No ☐ Yes
 PCOS ☐ No ☐ Yes Menstrual Migraines ☐ No ☐ Yes
 Endometriosis ☐ No ☐ Yes Breast / Uterine / Ovarian Cancer ☐ No ☐ Yes

MEDICAL HISTORY

- | | |
|---|---|
| ☐ High blood pressure | ☐ Prostate Issues |
| ☐ Heart disease/ Stroke/ High Cholesterol | ☐ HIV |
| ☐ Atrial fibrillation or other arrhythmia | ☐ Hemochromatosis / Anemia |
| ☐ Blood clot and/or a pulmonary embolism | ☐ Erectile Dysfunction |
| ☐ Depression/Anxiety/ Psychiatric Disorder | ☐ Thyroid Disease |
| ☐ Chronic liver disease (hepatitis, fatty liver, cirrhosis) | ☐ Diabetes / Prediabetes |
| ☐ Hair Loss/ Excessive Hair Growth | ☐ Cancer: _____ |
| ☐ Sleep apnea / Snoring | ☐ Lupus or other autoimmune disease |
| ☐ Kidney Disease | ☐ Other: _____ |
| ☐ Last Colonoscopy _____ | |

Surgical History/ Date:

_____	_____
_____	_____
_____	_____

FAMILY HISTORY / RELATION

- | | |
|--|--|
| ☐ Heart Disease _____ | ☐ Cancer/Type? _____ |
| ☐ Diabetes _____ | ☐ Stroke _____ |
| ☐ Osteoporosis _____ | ☐ Lung Disease _____ |
| ☐ Alzheimer's/Dementia _____ | ☐ Other: _____ |

HABITS

I exercise _____ times a week

Type(s) of exercises: _____ Duration (mins): _____

- | | |
|------------------------------|---|
| I use E-cigarettes / Vapes: | ☐ No ☐ Yes, _____ times per day |
| I smoke cigarettes / cigars: | ☐ No ☐ Yes, _____ times per day |
| I use Marijuana: | ☐ No ☐ Yes, _____ times per day |
| I drink alcoholic beverages: | ☐ No ☐ Yes, _____ drinks per day / week |
| I use caffeine: | ☐ No ☐ Yes, _____ times / cups per day |

FEMALE SYMPTOMS CHECKLIST

Place an "X" for EACH symptom you are currently experiencing. Please mark only ONE box per line.

For symptoms that do not apply, please mark NONE

	None	Mild	Moderate	Serious	Severe
Decline in your feeling of general well-being (general state of health, subjective feeling)	☐	☐	☐	☐	☐
Joint pain and muscular ache (lower back pain, joint pain, pain in a limb, general back ache)	☐	☐	☐	☐	☐
Hot flashes, excessive sweating (unexpected/sudden episodes of sweating, hot flushes independent of strain)	☐	☐	☐	☐	☐
Sleep problems (difficulty in falling asleep difficulty in sleeping through, waking up early and feeling tired, poor sleep, sleeplessness)	☐	☐	☐	☐	☐
Heart discomfort (unusual awareness of heartbeat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
Irritability (feeling aggressive, easily upset about little things, moody)	☐	☐	☐	☐	☐
Nervousness (inner tension, restlessness, feeling fidgety)	☐	☐	☐	☐	☐
Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
Physical / Mental exhaustion / lacking vitality (general decrease in performance, reduced activity, decrease in concentration, forgetfulness, feeling of getting less done, of achieving less, of having to force oneself to undertake activities)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)	☐	☐	☐	☐	☐
Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
Decrease in sexual desire/libido (lacking pleasure in sex, lacking desire for sexual intercourse)	☐	☐	☐	☐	☐

Please share any additional symptoms or comments about your symptoms you would like to address:

Do you have cold hands and feet? ☐ Yes ☐ No

Do you have daily bowel movements? ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No



HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. These policies have been our standard practice for years.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, www.hhs.gov.

We practice the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM

Print Name: _____

Signature: _____

Date: _____