WOMEN'S PELVIC HEALTH INSTITUTE
PETER CASTILLO MD, FACOG

Women's Pelvic Health Institute
Peter A. Castillo, M.D.
15215 National Avenue, Suite 104 · Los Gatos, California 95032
Telephone: 925-905-9922 Fax: 925-905-9925

FEMALE SYMPTOM QUESTIONNAIRE

CLIENT NAME: _____ DATE: _____

Please circle the appropriate number to indicate the frequency of the listed symptoms.
Descriptions of terms are found on the back of this page.

SYMPTOM	NONE					FREQUENT
Hot flashes	0	1	2	3	4	5
Fatigue	0	1	2	3	4	5
Night sweats	0	1	2	3	4	5
Low libido	0	1	2	3	4	5
Insomnia	0	1	2	3	4	5
Irritability	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Weight gain	0	1	2	3	4	5
Depression	0	1	2	3	4	5
Anxiety	0	1	2	3	4	5
Difficulty losing weight	0	1	2	3	4	5
Poor exercise tolerance	0	1	2	3	4	5
Cold body temperature	0	1	2	3	4	5
Cold hands & feet	0	1	2	3	4	5
Hair loss	0	1	2	3	4	5
Joint pain	0	1	2	3	4	5
Loss of muscle mass	0	1	2	3	4	5
Visual changes	0	1	2	3	4	5
Panic attacks	0	1	2	3	4	5
Breakthrough bleeding	0	1	2	3	4	5
Vaginal dryness	0	1	2	3	4	5
Menstrual bleeding	0	1	2	3	4	5
Unexplained nausea	0	1	2	3	4	5

SYMPTOM	NONE					FREQUENT
Memory lapses	0	1	2	3	4	5
Bone loss	0	1	2	3	4	5
Water retention	0	1	2	3	4	5
Dry skin	0	1	2	3	4	5
Urinary incontinence	0	1	2	3	4	5
Headaches	0	1	2	3	4	5
Tearful	0	1	2	3	4	5
Thinning skin	0	1	2	3	4	5
Uterine fibroid	0	1	2	3	4	5
Foggy thinking	0	1	2	3	4	5
Increased facial hair	0	1	2	3	4	5
Oily skin	0	1	2	3	4	5
Allergies	0	1	2	3	4	5
Acne	0	1	2	3	4	5
Heart disease	0	1	2	3	4	5
Decreased concentration	0	1	2	3	4	5
Swelling/puffy eyes	0	1	2	3	4	5
High blood pressure	0	1	2	3	4	5
High blood sugar	0	1	2	3	4	5
Chest pain	0	1	2	3	4	5
Shortness of breath	0	1	2	3	4	5
Other (listed below)						
	0	1	2	3	4	5

Please answer the following questions:

Do you feel you have enough energy to comfortably meet your goals?	Y	N
Do you find yourself exhausted during times of stress or excitement?	Y	N
Do you feel more awake, alert and energetic after 6 PM than you do all day?	Y	N
Do you have trouble sleeping without using medication?	Y	N
Do you have trouble getting up in the morning, even with adequate sleep?	Y	N
Are you feeling rundown or overwhelmed?	Y	N
Have you experienced increased weight gain in the stomach region over the past year?	Y	N
Are you struggling to maintain your weight?	Y	N
How many times per week do you exercise more than 30 minutes at a time?	_____times	
Do you have a decrease in strength and/or endurance?	Y	N
Do you often feel cold OR hot when other people do not complain of it?	Y	N
Are you satisfied with your skin?	Y	N
Is your hair falling out?	Y	N
Has your skin or hair become unusually dry lately?	Y	N
Is the outer 1/3rd of your eyebrows thinning?	Y	N
Have you experienced a brown patchy discoloration of the neck OR facial skin?	Y	N
Do you have abnormal hair gain on face, abdomen, or chest?	Y	N
Has your voice become more coarse lately?	Y	N
Do you have cramping or pain in your legs?	Y	N
When was your last menstrual period?	_____	
Are you experiencing night sweats, nausea, or hot flashes?	Y	N
Do you become emotional, anxious or irritated more easily than you used to?	Y	N
Are you more easily annoyed or angered by small issues than you should be?	Y	N
Are you less interested in sex than you used to be?	Y	N
Do you experience vaginal dryness or pain during intercourse?	Y	N

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PATIENT DEMOGRAPHIC INFORMATION

DATE:	NAME: FIRST M LAST	SEX (CIRCLE ONE)	DATE OF BIRTH:
		M F	/ /

ADDRESS		SSN	
CITY, STATE		ZIP CODE	
PRIMARY PHONE		OTHER PHONE	
OCCUPATION		MARITAL STATUS	S M D W
E-MAIL		REFERRAL	
EMERGENCY CONTACT		PHONE NUMBER	
PRIMARY CARE DOCTOR		PHONE NUMBER	

MEDICAL HISTORY

HISTORY OF:	CIRCLE ONE		IF YES, PLEASE LIST (INCLUDE DATE)
Medication allergies	Y	N	
Other allergies	Y	N	
Facial surgeries	Y	N	
Other surgeries	Y	N	
Dermal filler treatment	Y	N	
Botox treatment	Y	N	
Cosmetic treatments	Y	N	
Immunodeficiency	Y	N	
Autoimmune disorder	Y	N	
Lupus erythematosus	Y	N	
Keloid scarring	Y	N	
Bleeding/clotting disorder	Y	N	
HSV (coldsores)	Y	N	
Currently pregnant	Y	N	
Currently breastfeeding	Y	N	

Please list all other medical conditions: _____

CURRENT PRODUCTS & MEDICATIONS

What skincare products do you currently use? _____

_____

_____

Please express any concerns regarding treatment: _____

_____

_____

CURRENT MEDICATIONS AND SUPPLEMENTS	DOSE & FREQUENCY	REASON FOR TREATMENT

My signature certifies that the above information is complete and accurate to the best of my knowledge. I am not withholding any information from the Women's Pelvic Health Institute.

Patient Signature: _____ Date: _____

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BIO-IDENTICAL HORMONE REPLACEMENT THERAPY (BHRT) MEDICAL HISTORY

CLIENT NAME: _____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?	YES	NO
Diabetes	Y	N
Coronary vascular disease	Y	N
Heart attack	Y	N
Stroke	Y	N
Breast cancer	Y	N
Uterine cancer	Y	N
Ovarian cancer	Y	N
Deep vein thrombosis	Y	N
Pulmonary embolism	Y	N
Obstructive sleep apnea	Y	N
Hypertension	Y	N
Abnormal mammogram	Y	N
Abnormal pap smear	Y	N
Cardiovascular disease requiring:		
- Hospitalization	Y	N
- Angiogram with stent placement	Y	N
- Angiogram with other intervention	Y	N
- Coronary artery bypass graft (CABG)	Y	N
- Pacemaker placement	Y	N
- Medication	Y	N

DOES YOUR FAMILY HAVE A HISTORY OF:	YES	NO	AGE DIAGNOSED
Diabetes	Y	N	
Coronary vascular disease	Y	N	
Heart attack	Y	N	
Congestive heart failure	Y	N	
Stroke	Y	N	
Breast cancer	Y	N	
Uterine cancer	Y	N	
Ovarian cancer	Y	N	
Deep vein thrombosis	Y	N	
Pulmonary embolism	Y	N	
Prostate cancer	Y	N	
Obstructive sleep apnea	Y	N	
Hypertension	Y	N	

Please list any allergies to food, medications, or other substances: _____

_____

Please list any medical conditions: _____

Please list any past surgeries: _____

_____

Do you exercise? Yes No If yes, how many times per week? _____

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you smoke? Yes No If yes, how much per day? _____

Please list any family history of cancer: _____

CLIENT SIGNATURE: _____ DATE: _____

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CONSENT FOR HORMONE REPLACEMENT THERAPY

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by a medical practitioner of Women's Pelvic Health Institute. I acknowledge that there are no guarantees or assurances with respect to the benefit of hormone replacement therapy prescribed for me.

I understand that I will be in charge of administering these hormones and supplements prescribed to me.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with requests for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the practitioner any adverse reactions or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a relatively new specialty and there are no guarantees with respect to the treatment prescribed.

I understand that the role of the medical practitioner is for hormone replacement only. I agree that I am and will be under the care of another licensed physician for all other medical conditions. If I am a female, I agree that I will have an annual mammogram and physical examination with my primary care provider. If I am a male, I agree that I will have an annual physical examination with my primary care provider.

I have been informed that management for hormone therapy will not be billed to my insurance. I therefore agree to pay for all services myself at the time of service; including (but not limited to) initial consultation, pellets and/or topical creams, laboratory and pharmacy charges, and any follow-up visits and fees. I understand it is my responsibility to submit any claims to insurance if I desire reimbursement, with the understanding that I may not be reimbursed by my insurance company.

I have read and understand all of the above. The practitioner has discussed with me alternatives to bioidentical hormone therapy, including not getting treatment. I have been advised of the possibilities for increased risk of cancer, infertility, myocardial infarction, and blood clots. I had other information given to me about hormone replacement therapy so that I fully understand what I am signing and hereby request and consent to treatment using hormone replacement therapy.

Printed Name _____

Signature _____

Date (MM/DD/YYYY) _____