Blanche F. Petty, ARNP-BC

Patient Intake Form

Name:________________________________Date of birth:________________________________

Address:____

Phone:______________________Email:____

Emergency Contact:____________________________Phone:-_____________________________

May we text you? Circle YES NO

Are you under a Doctor's Care for any health conditions at this time? Circle YES   NO

If yes, please explain:____

Period occurs every: ___<21 days ___21-30 days ___>35 days How many days does it last?_____

Do you have menstrual cramps /pain? Circle YES   NO

If YES How Severe? Circle MILD MODERATE SEVERE

What do you use for contraception? _________________

Have you gone through menopause? Circle YES NO If YES At what age? _____

Date of Last Pap Smear? _______ Was it normal Circle YES NO

Have you ever had an abnormal Pap smear? Circle YES NO

If YES, did you have: Circle   Cryo   Colpo   Leep

Date of Last Mammogram? _____________ Was It Normal? Circle YES   NO

Have you had a bone density test (Dexa Scan)? Circle YES NO

Do you have complexion issues such as oily skin or acne? Circle YES NO

Do you have blood clotting issues? Circle YES NO

Tobacco use: YES NO If YES how many packs per day? ______ How many years? _____

How many alcoholic drinks weekly? ________

Have you ever had: Please Check Only those that apply:

___Vaginal Dryness/Itching ___Loss of muscle mass ___Fatigue ___Weight gain

___Breast Enlargement ___Bladder Symptoms ___Decreased Sex Drive ___Depression

___Night Sweats ___Irritability ___Breast Lumps ___Short Term Memory Issues

___Hair Loss ___Insomnia ___Headaches ___Nervousness ___Weakness/numbness

___Suicidal Thoughts ___Swollen Glands ___Breast lumps ___Anxiety ___Back pain

___Thyroid Disorder ___Cancer ___High Cholesterol ___Kidney Disease ___Heart disease

__Diabetes ___Hepatitis/Liver disease ___Osteoporosis ___Hypertension

___Hoarseness ___Coughing up blood ___Difficulty Breathing

List any disorders not listed above and explain:

____

____

Is there a family history of heart disease? Circle YES NO

If yes relationship_____________

Is there a family history of Cancer? Circle YES NO If yes relationship _________

Medication Allergies _________________________ What is your reaction?_________________

Please list all medications and over the counter supplements (include vitamins and inhaler, etc.)____

____

____

____

Sexual History

Are you sexually active? Circle YES NO

Do you ever have pain with intercourse? Circle YES NO

Is your Sex Life satisfactory? Circle YES NO

Sexual Preference_______ Male ________Female ______Both

Do you have decreased libido? Circle YES NO

(FEMALE) Do you have Vaginal dryness? Circle YES NO

(MALE) Do you have difficulty keeping and erection? Circle YES NO

Family History

Asthma: Y/N	Mental Illness: Y/N	Other Cancer: Y/N
Arthritis: Y/N	Stroke: Y/N	Parkinson: Y/N
COPD: Y/N	Seizures: Y/N	Alzheimer's: Y/N
Diabetes: Y/N	Breast Cancer: Y/N	Thyroid Disorder: Y/N
Heartburn: Y/N	Ovarian Cancer: Y/N	Bleeding disorder: Y/N
High cholesterol: Y/N	Uterine Cancer: Y/N	Clotting Disorder: Y/N
High Blood pressure: Y/N	Colon Cancer: Y/N	Anxiety/Depression: Y/N

I hereby agree that the information contained in medical history is accurate to the best of my knowledge.

Print name:______________________________ Date:________________

Signature: ______________________________

Please circle any service that you may be interested to learn more about:

Laser Body Slimming (VERJU)	Skin Tightening and Wrinkle Reduction (ENDYMED)
Vaginal Rejuvenation	BOTOX
B12 injection	MIC Injection