HYPOTHYROIDISM
HORMONAL IMBALANCES
MENOPAUSAL PROBLEMS
MALE/FEMALE SEXUAL DYSFUNCTION

HUGH D. MELNICK, M.D.

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FOR APPOINTMENTS/INFORMATION: AFSAPPOINTMENTS@GMAIL.COM

PATIENT INFORMATION SHEET ☐ THYROID ☐ HORMONAL

(Please print)

PATIENT CODE:_____ **DATE:**_____

PATIENT INFORMATION - (Please print)

NAME:_____ D.O.B_____ S.S.#_____
LAST FIRST MI

ADDRESS: _____ APT#_____ CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: HOME:_____ WORK:_____ MARTIAL STATUS:_____

OCCUPATION:_____ EMPLOYER:_____

E-MAIL:_____

PARTNER INFORMATION: IF APPLICABLE - (Please print)

NAME:_____ D.O.B_____ S.S.#_____
LAST FIRST MI

TELEPHONE: HOME:_____ WORK:_____

OCCUPATION:_____ EMPLOYER:_____

INSURANCE INFORMATION: THIS SECTION MUST BE COMPLETED - (Please print by the star *)

*PRIMARY CARRIER: _____ ADDRESS: _____

*ID/CERTIFICATE #: _____ *GROUP/CONTRACT #:_____

*SUBSCRIBER:_____ DATE OF BIRTH: _____ ☐ SELF ☐ SPOUSE ☐ OTHER

SECONDARY CARRIER: _____ ADDRESS: _____

*ID/CERTIFICATE #: _____ *GROUP/CONTRACT #:_____

*SUBSCRIBER:_____ DATE OF BIRTH: _____ ☐ SELF ☐ SPOUSE ☐ OTHER

EMERGENCY CONTACT INFORMATION: *THIS SECTION MUST BE COMPLETED*- (Please print)

IN CASE OF EMERGENCY, PLEASE NOTIFY:_____

RELATIONSHIP:_____ TELEPHONE #: _____

REFERRED BY

PRIMARY CARE PHYSICIAN/OB GYN:_____ TELEPHONE # : _____

ADDRESS:_____

I authorize the release of any medical or other information necessary to process any claims. I hereby agree to be financially responsible for payment of all medical services rendered to me or my family members and for fees which are not paid for by my insurance company. Should I default in payment and an attorney is needed to collect my outstanding balance, I will be responsible for not only my past due balance, but also all costs of collection. These costs may include interest and legal fees.

X_____ _____

Patient Signature or Authorized Signature Date

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PATIENT'S MEDICAL QUESTIONNAIRE

(PLEASE FILL ALL PAGES TO THE BEST OF YOUR ABILITY)

NAME:_____ DATE OF VISIT:_____
LAST FIRST

HEIGHT_____ (FT) WEIGHT:_____ (LBS) D.O.B_____ AGE:_____

PAST/ CURRENT MEDICAL HISTORY

1. MEDICAL HISTORY: PLEASE INDICATE YES OR NO FOR THE FOLLOWING OPTIONS_
   - DIABETES _____
   - HIGH BLOOD PRESSURE _____
   - CHOLESTEROL _____
   - HEART CONDITION _____
   - THYROID PROBLEMS _____
   - CANCER _____
   - URINARY PROBLEMS (PAJN OR FREQUENCY) _____
   - IF NOT LISTED PLEASE INDICATE BELOW:

_____

_____

2. CURRENT MEDICATION(S):_____

   A. PAST MEDICATION(S):_____

   B. ALLERGIES TO MEDICATION(S):_____

3. SURGICAL HISTORY: _____

4. GYNECOLOGCAL HISTORY: IF NOT APPLICABLE PLEASE NOTE *NIA*.

   A. PERVIOUS PREGNANCY/PREGNANCIES:

   LIVE BIRTH(S):_____ MISCARRIAGE(S)_____

   DATE/AGE OF YOUR FIRST PERIOD (MENARCHE):

   _____

   DURATION OF MENSTRUAL CYCLE (IN DAYS):

   _____

   BIRTH CONTROL METHOD(S) USED: _____

   ARE YOU SEXUALLY ACTIVE? HOW IS YOUR LIBIDO (SEX DRIVE)?

   _____

   DO YOU HAVE ANY PMS (MOOD CHANGES) BEFORE OR WITH YOUR PERIOD?

   _____

SYMPTOM QUESTIONNAIRE

PLEASEANSWER ALL QUESTIONS (circle yes or no)

			COMMENTS
o FATIGUE	YES	NO	
o DEPRESSION	YES	NO	
o WEIGHT GAIN	YES	NO	
o DIFFICULTY LOSING WEIGHT	YES	NO	
o WATER RETENTION	YES	NO	
o SENSITIVITY TO COLD	YES	NO	
o COLD HANDS FEET	YES	NO	
o HAIR LOSS	YES	NO	
o DRY HAIR	YES	NO	
o DRY SKIN	YES	NO	
o BRITTLE NAILS	YES	NO	
o LOW SEX DRIVE	YES	NO	
o MUSCLE/ JOINT PAIN	YES	NO	
o POOR MEMORY	YES	NO	
o DIFFICULTY CONCENTRATING OR AADD	YES	NO	
o CONSTIPATION	YES	NO	
o RINGING/TICKING IN EARS	YES	NO	
o TREMOR OR SHAKING	YES	NO	
o PALPITATIONS/IRREGULAR	YES	NO	
o HEART BEAT	YES	NO	
o SWEATY	YES	NO	
o NERVOUSNESS/ ANXIETY/PANIC ATTACKS	YES	NO	
o SLEEP DISTURBANCE/INSOMNIA	YES	NO	
o EXCESS BODY OR FACIAL HAIR	YES	NO	
o ACNE	YES	NO	

NOTES/COMMENTS

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PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.

√_____

Print Patient or Personal Representative Full Name

√_____

Signature of Pafient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority