Dr. James Webb & Associates

Patient Name:_____ DOB:_____

DRUG ALLERGIES: (Please circle)

Penicillin Sulfa Drugs Morphine Ibuprofen Tylenol Fentanyl Hydrocodone

Propofol Versed Barbituates IV Contrast Other:_____

Medication List

Name of Medication / Dosage / Frequency	Name of Medication / Dosage / Frequency

Have you taken any of the following medications?

Blood Thinner(s) YES NO Steroids (cortisone, prednisone) YES NO

Antidepressants YES NO Proton Pump Inhibitor (Nexium, Prilosec) YES NO

Hormone Replacement Therapy (Estrogen / Testosterone) YES NO

DO YOU HAVE OR HAVE YOU HAD:

Vertebral Fracture	YES	NO	Broken Bone as adult	YES	NO	Motor Vehicle Accident	YES	NO
Crohn's Disease	YES	NO	Ulcerative Colitis	YES	NO	Celiac Disease	YES	NO
Osteoporosis	YES	NO	Hip Fracture	YES	NO	Diabetes	YES	NO
HyperThyroid	YES	NO	HypoThyroid	YES	NO	Gastric Bypass Surgery	YES	NO
Heart Disease	YES	NO	Heart Attack	YES	NO	Bypass/Stents	YES	NO
Stroke	YES	NO	Aneurysm	YES	NO	Alzheimer's	YES	NO
Kidney Disease	YES	NO	Hypertension	YES	NO	Cancer	YES	NO
Mental Disorder	YES	NO	Alcoholism	YES	NO	Drug Abuse	YES	NO
Migraines	YES	NO	Fall from Height	YES	NO			

Other Current Health Problems:

_____

SURGERIES

Year	Reason	Hospital Name

Do you use marijuana? YES NO Do you have a medical marijuana card? YES NO

Do you smoke/chew tobacco/vape? YES NO if so, how much/often?_____

Do you drink alcohol? YES NO if so, how much/often?_____

Do you use drugs? YES NO if so, how much/often?_____

Do you exercise regularly? YES NO if so, how much/often?_____

Sexually Active? YES NO Birth Control Method? _____

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Patient Name:_____DOB:_____

Family History

	Living	Deceased	If deceased, please list cause:
Father	☐	☐	_____
Mother	☐	☐	_____
Siblings	☐	☐	_____
	☐	☐	_____
Children	☐	☐	_____
	☐	☐	_____

Any Family history of:	Yes	No	Who?		Yes	No	Who?
Heart Disease	☐	☐	_____	Stroke	☐	☐	_____
Hypertension	☐	☐	_____	Cancer	☐	☐	_____
Diabetes	☐	☐	_____	Alcoholism	☐	☐	_____
Mental Disorder	☐	☐	_____	Hip Fracture	☐	☐	_____
Thyroid Disorder	☐	☐	_____	Osteoporosis	☐	☐	_____
Kidney Disease	☐	☐	_____	IBD/IBS	☐	☐	_____

For Women Only:

Last Menstrual Period_____ Date of Last Mammogram:_____ Age at Menopause_____

Hysterectomy? YES NO Do you have your ovaries? YES NO Date of Hysterectomy:_____

History of Breast Cancer YES NO

For Males Only:

History of Low Testosterone: YES NO Have you taken Testosterone before: YES NO

Prostate Issues: YES NO

Dr. James Webb & Associates 918-260-9322

Patient Name:_____ DOB:_____

HRT Health Assessment

When did you first notice these symptoms? 1-2 Mo 2-4 Mo 3-6 Mo 6-12 Mo Over 1 Yr

Symptom *(please check mark)*	Never	Mild	Moderate	Severe
Fatigue				
Irritability				
Anxiety				
Depression				
Memory Loss				
Brain Fog				
Lack of Concentration				
Weight Gain				
Bloating				
Insomnia				
Can't Stay Asleep				
Decreased Muscle Strength				
Hair Loss				
Joint Pain				
Decreased Sex Drive				
Cold Hands &Feet / Always Cold				
Dry Skin				
Pain During Sex				
Vaginal Dryness				
Hot Flashes				
Night Sweats				
Headaches				
Breast Tenderness				

How often do these symptoms affect your daily life? DAILY WEEKLY MONTHLY

Are you currently on Hormone Replacement Therapy? Yes No

Are you planning to conceive in the future? Yes No

What is your method of Birth Control? None Menopause Hysterectomy Tubal Ligation BC Pills
IUD Condoms Vasectomy Abstinence

Do you have a history of Seizures or Epilepsy? Yes No