NuWave Medical, PLLC

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New Patient Intake — Women's Health

Please complete this form before your first visit. All information is kept confidential.

1. Patient Information

Name _____ **Date of birth** _____
Date completed _____ **Age** _____
Phone _____ **Email** _____
Pharmacy: _____

2. Reason for Your Visit

Main concern or reason for today's visit:
_____

How long have you had these concerns? _____ (weeks / months / years)

What are you hoping for? (check all that apply): ☐ Symptom relief ☐ Hormone therapy ☐ Review current treatment ☐ Preventive care ☐ Second opinion

3. Menstrual & Menopausal History

Age periods started _____ **Date of last period** _____

Current status: ☐ Regular periods ☐ Irregular periods ☐ Perimenopause ☐ Menopause ☐ Periods stopped after surgery

Have your ovaries been removed? ☐ Yes ☐ No ☐ Not sure

If menopause was early or surgical, please add details:
_____

4. Symptoms — How You've Felt Over the Past Month

Symptom (check one box per row)	None	Mild	Moderate	Severe
Hot flashes / flushing	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Pain with intercourse	☐	☐	☐	☐
Low sex drive (libido)	☐	☐	☐	☐
Urinary urgency or leakage	☐	☐	☐	☐
Brain fog / memory changes	☐	☐	☐	☐
Low mood or depression	☐	☐	☐	☐
Anxiety or irritability	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Trouble sleeping / insomnia	☐	☐	☐	☐

Symptom (check one box per row)	None	Mild	Moderate	Severe
Fatigue / low energy	☐	☐	☐	☐
Headaches or migraines	☐	☐	☐	☐
Joint or muscle aches	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐
Hair thinning	☐	☐	☐	☐
Dry or thinning skin	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐
Heart palpitations	☐	☐	☐	☐

Other symptoms not listed above:

_____

5. Medical History

Height: _____ **Weight:** _____

Have you ever been diagnosed with any of the following? (check all that apply)

☐ High blood pressure ☐ Heart disease ☐ Stroke / TIA ☐ Blood clots (DVT / PE)
☐ Breast cancer ☐ Uterine / ovarian cancer ☐ Other cancer ☐ Abnormal mammogram
☐ Diabetes / prediabetes ☐ Thyroid disease ☐ PCOS ☐ High cholesterol
☐ Liver or gallbladder disease ☐ Migraines with aura ☐ Osteoporosis / low bone density ☐ Depression / anxiety

Any other conditions or details:

_____

6. Surgical History

Hysterectomy (uterus removed): ☐ Yes ☐ No
Ovary removal (one or both): ☐ Yes ☐ No
Tubal ligation: ☐ Yes ☐ No
Breast surgery (biopsy, reduction, implants, mastectomy): ☐ Yes ☐ No
Other surgeries and approximate dates:

_____

7. Family History

Has a close relative had any of the following? (check all that apply)

☐ Breast cancer ☐ Ovarian cancer ☐ Uterine cancer ☐ BRCA gene mutation
☐ Blood clots ☐ Heart disease / stroke ☐ Osteoporosis ☐ Early menopause (under 45)

Other relevant family history: _____

_____

8. Medications, Supplements & Allergies

Current prescription medications (name & dose):

_____

_____

_____

_____

Vitamins, supplements, or herbal products:

_____

Have you used hormone therapy (HRT) before? ☐ Yes ☐ No
If yes, what type and when? _____

Do you have any allergies: _____

9. Reproductive & Sexual Health

Number of pregnancies _____ **Number of births** _____
Currently sexually active? ☐ Yes ☐ No ☐ Prefer not to say
Any sexual health concerns or goals you'd like to discuss?
_____

10. Lifestyle

Tobacco use: ☐ Never ☐ Former ☐ Current
Alcohol use: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
Sleep quality: ☐ Good ☐ Fair ☐ Poor
Exercise (days/week & type): _____
General diet: _____
Are you under significant stress right now? ☐ Yes ☐ No

11. Screening & Preventive Care

Screening test	Date of last test	Approx. result (if known)
Mammogram		
Pap smear / HPV test		
Bone density (DEXA)		
Colonoscopy		
Bloodwork / labs		

Questions or concerns you'd like to be sure we cover:
_____

I confirm the information above is accurate to the best of my knowledge.

Patient signature: _____ Date: _____

Reviewed by Provider: _____ Date: _____