ROCKY MOUNTAIN NATURAL MEDICINE

Dr. Jason Barker & Dr. Holly German
313 West Drake Road, Suite 210 · Fort Collins, CO 80526
Phone: 970-237-1062 · www.fortcollins-naturalmedicine.com

Welcome!

Congratulations on your decision to get healthy, naturally! We look forward to helping you achieve true health and wellness.

Naturopathic Doctors are considered the nation's leading experts in preventive medicine and natural health care; you can feel confident you made the right choice.

Please complete the attached intake forms that will help us to assess your current state of health. A full medical and symptom history is the start of this very individualized process.

We look forward to meeting with you, and helping to change your health for the better!

In Health,

Jason Barker, ND
Holly German, ND

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Focused Nutritional Supplementation – Quality is Paramount!

Anyone can formulate and sell nutritional supplements. Health magazine articles, multi-level marketing campaigns, and product labels can be as confusing as they are misleading.

Supplements, like any other product, can be made with good or poor quality. Unfortunately, the majority of supplements available today are poor quality, costing you in terms of both money and lost health opportunities.

It can be difficult to know the difference between a high quality, useful supplement and one that is worthless. The FDA regulates nutritional supplements only in regard to what goes on the label -they do not in any way oversee the purity and potency of any supplement!

For this reason, we will recommend and make available to you only the highest quality supplements and natural medicines. The supplements we provide contain exactly what they say they do; they are quite potent and will therefore produce effective changes in your health.

Since 1997, we've has been researching, writing, and lecturing about the truths and myths of nutritional supplementation. His nutritional information comes from peer-reviewed medical journals – countless research hours have afforded him the opportunity to sift through the data, evaluate which studies are valid (and which are not) and ultimately select the most effective supplements for his patients.

The supplements we carry do not contain any impurities. None of them contain any banned ingredients or drugs. They are hypoallergenic and contain no dyes, fillers, shellacs or any other nonsense.

All of the supplements we provide adhere to *Good Manufacturing Practices* (cGMPs). This means they were manufactured according to a comprehensive system of controls, ensuring that all processing is completed in a consistent and reproducible manner.

As part of your ongoing treatment, our doctors will recommend specific, high quality supplements that are not found "over the counter". In order to receive the most benefit from your care, it's important that you continue with the recommendations in your treatment plan. Trying to substitute with less expensive versions will end up costing you in terms of lost health opportunities, time and money. We offer periodic discounts on supplements to help you stay on your routine.

CONFIDENTIAL INTAKE FORM

ROCKY MOUNTAIN NATURAL MEDICINE

Name: _____ **Date:** _____
(Please print clearly)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____
(We promise not to sell, trade or otherwise disclose your email to anyone. We use your email for scheduling and our newsletter that is full of great information and client-only specials).

Phone: _____ **Cell:** _____
(Please include area code)

I give Rocky Mountain Natural Medicine my permission to leave phone messages regarding my appointments. Yes _____ **No** _____

Birth date: _____

How did you hear about us? _____

_____
Please let us know how you heard about us. As always, we like to say "Thank You" to our referral sources.

Thank you and we look forward to helping you get healthier!

DISCLOSURE STATEMENT AND INFORMED CONSENT

ROCKY MOUNTAIN NATURAL MEDICINE

This document is a binding agreement (the "Agreement") between ROCKY MOUNTAIN NATURAL MEDICINE Inc. ("We" "Us") and the individual patient whose name and signature appears below ("You" "Your"). In consideration of the health care services provided to You by Us at the present and at all times in the future, You agree as follows:

Consent for Treatment: You hereby consent to and authorize us to provide you with heath care treatment that involves natural health and wellness. You understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risk. You have the right, as a patient, to be informed about your condition and the recommended integrative and complementary procedure to be used so that you make an informed decision whether or not to undergo the treatment after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the treatment or procedure.

Services: Naturopathic Medicine is a branch of the healing arts distinct from other branches. Our services include the prevention, evaluation, diagnosis, and treatment of injuries, diseases, and conditions through education, nutrition, naturopathic preparations, natural medicines, physical medicine, physical agents, and other therapies and modalities designed to support the body's natural healing processes. Our Naturopathic Doctors (ND) are registered under the Colorado Naturopathic Doctor Act. They are not Medical Doctors (MD), Doctors of Osteopathy (DO), Doctors of Chiropractic (DC), or Doctors of Nursing (DNP) who are licensed under separate practice acts. As Naturopathic Doctors in Colorado, we do not prescribe, dispense, administer, or inject controlled substances (including general or spinal anesthetics) or practice medicine (including performing surgery, obstetrics, or administering ionizing radiation therapy). The only adjustments, manipulations, and mobilizations we perform are naturopathic manual therapies. We cannot recommend against a course of care recommended or prescribed by a licensed provider in another branch of the healing arts. Our office does not provide naturopathic treatment to children less than two years old. We recommend that our pediatric patients follow the CDC immunization schedule (copy attached) and have a relationship with a licensed pediatric health care provider.

Risks: I understand that no warranty or guarantee has been made to me as to the result of care. I realize that just as there may be risks and hazards in continuing my present condition without conventional medical treatment, there are also risks and hazards related to the performance of the integrative and complementary treatment(s) planned for me. Naturopathic Medicine is generally considered safe but may involve some risks including, without limit: all of the risks disclosed with any preparations or medicines; allergic reaction; infection; pain or discomfort; weakness, fainting, or nausea; skin irritation, discoloration, or scarring; aggravation of symptoms; mood changes; and rarely, neurological injury and pneumothorax. Naturopathic Medicine may adversely interact with specific drugs and may be inappropriate during pregnancy.

Alternatives and Collaboration: Alternatives to Naturopathic Medicine include declining such care and consulting with others such as an MD, DO, DC, or DNP. Naturopathic Medicine is not a substitute for other types of health care and we encourage you to seek second opinions, have a relationship with an MD or DO, to communicate with all your providers about the care recommended in our office, and to authorize us to attempt to collaborate with your other providers. If applicable, please identify the provider with whom we should attempt to collaborate:
Provider: _____ Phone: _____.

EMERGENCIES: If you are having a medical emergency, do not wait to seek care. Call 911.

NO GUARANTEE: Every individual responds to care differently and no guarantee or assurance is made as to the results of care in any specific case, as care may not improve your condition.

PAYMENT, INSURANCE, AND REFUNDS: Our fee schedule is attached. Payment for services is not conditional on response to care. There is no guarantee of insurance coverage. Any insurance you have is an agreement between you and your insurance carrier and you are responsible for payment of services, whether or not they are covered by insurance. You may terminate care at any time. Prorated fees for unused, prepaid services will be refunded; however, no refunds are available for product purchases.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND!

I have read and fully understand this consent form, and understand that I should not sign this form if any of my questions have not been explained to my satisfaction or if I do not understand any of the terms or words.

Patient or Person with Authority to Consent: _____ **Date:** _____

FINANCIAL POLICY

ROCKY MOUNTAIN NATURAL MEDICINE

Thank you for choosing Rocky Mountain Natural Medicine for your Naturopathic health care! We are committed to giving you the best care possible, and we want you to completely understand our financial policies. The following is a statement of our Financial Policy, which we need you to read and sign prior to any treatment.

- Payment is due at time of service unless arrangement have been made in advance. Your financial responsibility to us is your cash fee. We accept cash, check and credit cards (Visa, MasterCard).

- Your insurance plan will most likely not cover the services of our services. In the State of Colorado, Naturopathic health care is not yet covered by any insurance plans. However, you may submit your own claim to your insurance company; in rare events some portions of service may be reimbursable to you. Additionally, nutritional supplements prescribed may be eligible under your Health Savings Account. Ultimately it is your responsibility to understand what your insurance plan will and will not cover. We can help by providing you with the applicable codes to submit for reimbursement.

- Because our services are not covered by insurance, you are responsible for the complete charge. Payment is due upon the receipt from our office.

- The following are some, but not all of the costs of our services, depending on complexity of the case:
  - New Patient: $220
  - New Patient, Pediatric: $155
  - Follow up visits: $90-$45
  - Follow up visit, Pediatric: $60

Laboratory services:

- We use a variety of testing methods to help with diagnosis. Some tests may be covered by insurance, and some are not. Your doctor will review them with you during your visit.
  For example:
  - Saliva hormone profiles range from $185-$280
  - Food allergy tests are $249
  - Gastrointestinal tests range from $310-$418
  - Standard laboratory blood work: Depending on your own insurance plan or we can order at wholesale pricing.

I have read and understand ROCKY MOUNTAIN NATURAL MEDICINE Inc.'s FINANCIAL POLICY AGREEMENT, and I agree to be bound by its terms.

_____ _____

Patient Signature (or Responsible Party if a minor) Date

_____

Printed Name

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT

ROCKY MOUNTAIN NATURAL MEDICINE

313 West Drake Road, Suite 210, Fort Collins, CO 80526
www.fortcollins-naturalmedicine.com

This notice describes how your health information may be used and disclosed. Please review it carefully.

Your Rights

You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say "no," but if we do, we'll tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree to your request and we may say "no". If, however, you pay for a service or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information
- Obtaining a list (accounting) of those with whom we've shared your information for six years prior to the date you ask, who we shared it with and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint if you feel we have violated your rights by contacting: 313 West Drake Road, Suite 210, Fort Collins, CO 80526, (970) 237-1062; or U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Ave, S.W. Washington, D.C. 20201, 1-877-696-6775, www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against anyone for filing a complaint.

Your Choices

- You have the right and choice to have us share information with family, friends, or others involved in your care; share information in a disaster relief situation; or include your information in a hospital directory.
- We will not sell your information or share it for marketing unless you give us written permission. We may, however, contact you for fundraising efforts, but you can tell us not to contact you again.
- We will not share psychotherapy notes unless you give us written permission.

If you are not able to tell us your choice, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

We can use your health information and share if with others for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENT (CONT.)

We are also allowed or required to share your information in other ways, such as:

- Providing you with information related to your health
- Contacting you regarding appointments, treatment alternatives, or other health related services
- Incidental uses or disclosures (e.g. listing your name on a sign-in sheet etc.)
- Compliance with all laws (including reports of adverse reactions, suspected abuse, neglect or violence)
- Providing information to law enforcement or correctional facilities
- Providing information to a coroner, medical examiner, funeral director, or for organ procurement
- Public health activities when requested by a public health authority or the FDA
- Responding to health oversight agencies
- Responding to court or administrative orders, subpoenas, discovery requests or lawful process
- Research activities
- When necessary to avert a serious threat to health or safety
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities
- Providing information regarding your location, general condition or death to disaster relief agencies
- Providing information for workers' compensation claims
- Informing a family member, other relative, or close personal friend when:
    - Information is relevant to the individual's involvement with your care
    - To assist in your health care (pick-up prescriptions or documents, follow-up care instructions etc.)

Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

Our Responsibilities

We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

Change to the Terms of this Notice

We reserve the right to change the terms of this notice. The newly effective notice will be posted in our office, on our website, and will be available upon request. This notice is effective July 1, 2014. For more information see: *www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html*

Patient Acknowledgement

I acknowledge receiving a copy of this notice regarding the use and disclosure of my health information.

_____ _____

Signature of Patient/Legal Guardian *Date*

_____ _____

Print Patient Name (required) *Print Legal Guardian Name (if necessary)*

INTERNAL PRACTICE USE ONLY: _____ refused to sign.

_____ _____

Signature of Practice Representative *Date*

CANCELLATION & MISSED APPOINTMENT POLICY

ROCKY MOUNTAIN NATURAL MEDICINE

In order to better serve you, please let us know 24 hours ahead of your appointment if you are unable to make it. This lets us provide other patients awaiting an appointment the opportunity to receive care.

We realize that things come up; kids get sick, emergencies happen, etc. In these cases of course you can't give 24-hour notice but do please try to call and let us know if you'll be late or need to reschedule, ok?

If you miss an appointment without providing at least a 24-hour notice you may be responsible for a $75 missed appointment charge.
(*FYI this is for repeat offenders!*)

Thanks!

_____ _____

Patient Signature (or Responsible Party if a minor) Date

_____

Printed Name

NAME: _____ **DATE:** _____

Present health issue(s): _____

_____

When did it/they begin? (date) _____

What percentage of the time does it bother you? (circle one) < 10% 25% 50% 75% 100%**What treatments (if any) have you received for your present health issue(s)?** _____

_____

_____

List your major health concerns in order of importance:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Medications and prescriptions you are currently taking:	**Dosage**	**Reason for taking**	**How long?**

Supplements you are currently taking:	**Dosage**	**Reason for taking**	**How long?**

Hospitalizations:

For what reason	**When**

Sleep (# of hours and quality): _____

Stress level (circle one): 1 Minimal 2 3 Somewhat minimal 4 5 Moderate 6 7 Somewhat extreme 8 9 Extreme

Allergies:

Medications: _____
Food: _____
Environmental: _____

Place a check mark next to the food/drink that applies to your current diet.

Usual breakfast	✓	**Usual lunch**	✓	**Usual dinner**	✓
None		None		None	
Artificial sweetener		Artificial sweetener		Artificial sweetener	
Bacon/Sausage		Coffee		Beans (legumes)	
Bagel		Eat in a cafeteria		Brown rice	
Butter		Eat in a restaurant		Butter	
Cereal		Sandwich		Carrots	
Coffee		Juice		Coffee	
Donut		Leftovers		Eat in a cafeteria	
Eggs		Lettuce		Eat in a restaurant	
Fruit		Milk		Fish	
Granola		Nuts/nut butter		Green vegetables	
Juice		Salad		Juice	
Leftovers		Salad dressing		Margarine	
Margarine		Seeds		Milk	
Milk		Soda		Pasta	
Nuts/nut butter		Soup		Potato	
Oatmeal		Sugar		Pork	
Pastry		Tea		Poultry (chicken, turkey)	
Seeds		Water		Red meat	
Sugar		Yogurt		Rice	
Tea		Other (list below):		Salad	
Toast				Salad dressing	
Water				Soda	
Yogurt				Sugar	
Other (list below):				Tea	
				Water	
				Yellow vegetables	
				Other (list below):	

How much of the following do you consume each week?

Food	**Amount/week**
Candy	
Cheese	
Chocolate	
Cups of caffeinated coffee	
Cups of decaffeinated coffee or tea	
Cups of caffeinated tea	
Diet sodas	
Ice cream	
Salty foods	
Slices of white bread (including rolls and bagels)	
Sodas with caffeine	
Sodas without caffeine	

Please fill in the chart below with information about your bowel movements:

Frequency	✓	Consistency	✓	Color	✓
More than 3x/day		Soft and well formed		Medium brown consistently	
1-3x/day		Often float		Very dark or black	
4-6x/week		Difficult to pass		Greenish color	
2-3x/week		Diarrhea		Blood is visible	
1 or fewer x/week		Thin, long or narrow		Varies a lot	
		Small and hard		Dark brown consistently	
		Loose but not watery		Yellow, light brown	
		Alternating between hard and loose/watery		Greasy, shiny appearance	

Have you ever used alcohol? Yes ____ No ____

If yes, how often do you currently drink alcohol?
____No longer drinking alcohol
____ Average 1-3 drinks per week
____ Average 4-6 drinks per week
____ Average 7-10 drinks per week
____ Average > 10 drinks per week

Have you ever had a problem with alcohol? Yes ____ No ____

If yes, please indicate time period (month/year): From _____ To _____

Have you ever used recreational drugs? Yes ____ No ____

Have you ever used tobacco?

If yes, number of years as a nicotine user _____. **Amount per day _____.** **Year quit _____.**
If yes, what type of nicotine have you used? ____Cigarette ____ Smokeless ____ Patch/Gum ____Cigar ____ Pipe

Are you exposed to second hand smoke regularly? Yes ____ No ____

Have you ever had psychotherapy or counseling? Yes ____ No ____

Currently? _____ **Previously?** _____ **If previously, from** _____ **to** _____.
What kind? _____
Comments: _____

Are you currently, or have you ever been married? Yes ____ No ____

If so, when were you married? _____ **Spouse's occupation** _____
When were you separated? _____ **Never** _____
When were you divorced? _____ **Never** _____
When were you remarried? _____ **Never** _____ **Spouse's occupation** _____
Comments: _____

Hobbies and leisure activities: _____
_____

Do you exercise regularly? Yes ____ No ____

If so, how many times a week?
_____ 1x
_____ 2x
_____ 3x
_____ 4x or more

When you exercise, how long is each session?
_____ ≤ 15 min
_____ 16-30 min
_____ 31-45 min
_____ > 45 min

What type of exercise is it? _____ _____ _____

What is your occupation: _____

FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:

1. **Their present state of health, and**
2. **Any illnesses they have had.**

(*Note: Except for spouse, family refers to blood or natural relatives.)* PRINT NAMES BELOW	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies	Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Disease	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer
Father:																				
Mother:																				
Brother/Sisters:																				
Spouse:																				
Child:																				
Child:																				
Child:																				
Child:																				
Paternal relatives (in each box, write in how many affected with condition):																				
Maternal relatives (in each box, write in how many affected with condition):																				

Any other family history we should know about? Yes ____ No ____

If yes, please comment: _____

_____

Medical History: for past medical conditions indicate year, for present conditions check appropriate box.

Head	**PAST**(year)	**PRESENT**
Allergies		
Dizziness		
Epilepsy/Seizures		
Fainting		
Headaches		
Migraines		
Sinus Problems		
Stroke		

Eyes, Ears, Nose, Throat	**PAST** (year)	**PRESENT**
Dark circles below eyes		
Distorted smell		
Distorted taste		
Dry eyes		
Ear fullness		
Ear pain		
Ear ringing/buzzing		
Eye pain		
Glaucoma		
Hearing problems		
Sore gums		
Sore throat		
Sore tongue		
Swollen glands		
Vision problems		
Watery, itchy red eyes		
Yellowing eyes		

Heart	**PAST** (year)	**PRESENT**
Anemia		
Easy bleeding/bruising		
Heart attack		
Heart disease		
Heart murmur		
High blood pressure		
High cholesterol		
High triglycerides		
Varicose veins		

Urinary	**PAST** (year)	**PRESENT**
Bed wetting		
Hesitancy		
Infection		
Kidney disease		
Kidney stones		
Leaking/incontinence		
Pain/burning		
Urgency		

General	**PAST**(year)	**PRESENT**
Alcoholism		
Cancer		
Cold intolerance		
Daytime sleepiness		
Diabetes		
Early waking		
Fatigue		
Fever		
Flushing		
Frequent illness		
Gout		
Heat intolerance		
Insomnia		
Mononucleosis		
Overweight		
Poor circulation		
Rheumatic fever		
Stroke		
Swollen ankles/feet		
Thyroid disease		
Weight gain		
Weight loss		

Musculoskeletal	**PAST**(year)	**PRESENT**
Arthritis		
Back pain		
Joint pain		
Muscle pain		
Back muscle spasm		
Calf cramps		
Chest tightness		
Foot cramps		
Joint redness		
Joint stiffness		
Muscle stiffness		
Muscle twitches		
Muscle weakness		
Tendonitis		
Tension headaches		

Medical History (continued): for past medical conditions indicate year, for present conditions check appropriate box.

Skin	**PAST** (year)	**PRESENT**
Acne		
Bumps on back of arms		
Cracked skin		
Cuticle problems		
Discoloration		
Dry skin		
Fingernail problems		
Hair changes		
Hair loss		
Hives		
Itching – where?		
Itchy feet		
Psoriasis		
Rashes		
Shingles		
Strong body odor		

Stomach/Digestive	**PAST** (year)	**PRESENT**
Bad taste in mouth		
Binge eating		
Black stools		
Bleeding gums		
Blood in stools		
Burning in throat		
Burping		
Canker sores		
Cold sores		
Constipation		
Diarrhea		
Difficulty swallowing		
Dry mouth		
Gas/bloating		
Gum disease		
Heartburn		
Hemorrhoids		
Hepatitis		
Hypoglycemia (low blood sugar)		
Indigestion		
Lip cracking		
Nausea/vomiting		
Rectal bleeding/fissures		
Stomach pain		
Ulcers		
Undigested food in stools		
Vomiting blood		

Respiratory	**PAST** (year)	**PRESENT**
Asthma		
Bad breath		
Bad odor in nose		
Bronchitis		
Cough		
Emphysema		
Hay fever		
Nasal stuffiness		
Pneumonia		
Post nasal drip		
Sinusitis		
Sleep apnea		
Sore throat		
Wheezing		

Mental/Emotional/Nerves	**PAST** (year)	**PRESENT**
Anxiety		
Awaken rested		
Depression		
Difficulty concentrating		
Difficulty with balance		
Difficulty with judgment		
Difficulty with memory		
Difficulty with speech		
Difficulty with thinking		
Dizziness (spinning)		
Fainting		
Fear		
Fears/phobias		
Irritability		
Light headed		
Numbness		
Numbness/tingling		
Panic attacks		
Poor memory		
Sleeping difficulty		
Tremors		

Medical History (continued): for past medical conditions indicate year, for present conditions check appropriate box.

Male Reproductive	**PAST** (year)	**PRESENT**
Discharge from penis		
Enlarged breasts		
Genital pain		
Impotence		
Infection		
Low sex drive		
Prostate enlargement		
Prostate infection		
Urine stream sprays		

Female Reproductive	**PAST** (year)	**PRESENT**
Age at menopause (if applicable)		
Age at onset of first period		
Birth control pills		
Bleeding after menopause		
Bleeding between periods		
Breast cysts		
Breast lumps		
Breast pain		
Breast tenderness		
Endometriosis		
Excessive bleeding		
Excessive pain with periods		
Fibroids		
Hormone replacement therapy		
Infertility		
Irregular periods		
IUD		
Last period (date)		
Low sex drive		
Number of miscarriages		
Number of pregnancies		
Ovarian cyst		
Painful intercourse		
PMS		
Polycystic ovarian syndrome		
Routine annual breast exam		
Routine mammogram		
Routine self breast exam		
Scanty periods		
Skipped periods		
Vaginal discharge		
Vaginal dryness		
Vaginal itching		

Other	**PAST** (year)	**PRESENT**