G. DeAn Strobel, MD, PA
Hormonal Balance & Wellness
G. DeAn Strobel, MD * Karissa L. Cryer, DO * Angelica Ortiz, FNP * Katie Green, FNP
230 East Sycamore Street * Suite 200 * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279
Save this on your computer then email to: info@drdeanstrobel.com

Patient Name ____ Birthdate _______________Today's date: ________________

MEDICAL & FAMILY HISTORY FORM

Do you: Smoke? YES or NO If yes, how many packs per day _________ # Years smoked ___________
Drink Alcohol? YES or NO If yes, how many drinks per day? _________
Drink soda/coffee/tea? ____________ How many per day? _____________________
Use artificial sweeteners? _________ How much per day? ____________________
Do you have problems with milk or dairy products? YES or NO Other foods? _______________________

List the prescription and over-the-counter medications you are now taking:

________________________________ __________________________________ _________________________________
________________________________ __________________________________ _________________________________

List any supplements, herbs or vitamins that you are taking:

________________________________ __________________________________ _________________________________
________________________________ __________________________________ _________________________________

Are you interested in weight loss? If so, please list all medications, products that you have tried in the past and how they worked for you. Also, list any special diets or meal plans that you have tried in the past.

________________________________ __________________________________ _________________________________
________________________________ __________________________________ _________________________________

List any allergies you have to drugs, food or other items:

________________________________ __________________________________ _________________________________
________________________________ __________________________________ _________________________________

Are you currently under medical care for any reason(s)? If yes, please explain: _____________________________________
____

WOMEN ONLY:

Age when menstrual periods began ___________________
Are your periods regular? ___________________ How Often? ___________
How many days do your periods last? ___________________
How many times have you been pregnant? ___________________
How many children born alive? ___________________
Are you menopausal? YES or NO If yes, did this occur NATURALLY or SURGICALLY? And at what age? __________

Past Psychiatric/Mental Health Care: YES or NO

Therapist's Name: _______________________________ For How Long and When: ______________

List all procedures, operations, or surgeries:

Operation/procedure performed	Year	Hospital	Doctor

List all times you have been admitted to a hospital overnight (except for childbirth and surgeries listed above)

Reason Hospitalized	Year	Hospital	Doctor

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Have you had any of the following illnesses or conditions: (Please check all that apply)

Measles	Diabetes	Typhoid	Chronic constipation/diarrhea
Rubella (German measles)	Goiter/thyroid disease	Malaria	Ulcerative colitis or Crohn's
Chickenpox	Hives	Other tropical diseases	Rheumatoid arthritis
Mumps	Allergies	Hepatitis	Hashimoto's
Whooping cough	Eczema/psoriasis	Venereal disease or sexually transmitted infection	Osteopenia or osteoporosis
Scarlet fever	Mononucleosis	Seizures	Stroke or TIA
Tonsillitis	Rheumatic fever	Meningitis	Blood clots/DVT or pulmonary embolism
Diphtheria	Poliomyelitis	Ear infections	Glaucoma
Asthma	Pleurisy	Heart murmur	Bronchitis
High blood pressure	Low blood pressure	Migraine headaches	Angina or chest pain
Tuberculosis	Heart attack	Infertility	Ulcer
Phlebitis	Kidney stones	Low hormones or low testosterone	Bladder or kidney infection
Depression or anxiety	Heart stent	Heart arrythmia	Cancer

WOMEN ONLY:

Endometriosis	Breast cancer	Uterine cancer	Ovarian cancer
Uterine fibroids	Uterine polyps	Abnormal pap smear	Menstrual migraines
Fibrocystic breast disease	Breast pain	Prior breast biopsy	

MEN ONLY:

Enlarged prostate	Difficulty urinating or emptying bladder completely	Erectile problems	Chronic constipation/diarrhea
Rubella (German measles)	Goiter/thyroid disease	Malaria	Ulcerative colitis or Crohn's

Other serious illnesses: (Please Explain) ____
____
____

Please list the date and results (if known and if applicable) of your last:

Bone Density Scan: ____Date:________________________________
Mammogram: ____ Date:________________________________
X-ray: ____ Date:________________________________
EKG: ____Date:________________________________
Blood Count: ____Date:________________________________
Cholesterol: ____ Date:________________________________
Blood chemistry: ____ Date:________________________________
Date of last examination by a doctor: __________ Doctor _________________ Results: ___________________________
____

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PERTINENT SEXUAL HISTORY

Concerns about sexuality are sometimes difficult for many patients to discuss. These issues are important to discuss to evaluate risks AND to help with any concerns. In order to better address your needs, please answer the following questions.

Are you currently sexually active? YES or NO   Sexual preference: MALE(S) FEMALE(S) BOTH

If over the age of 18 and you are not sexually active, is there a medical condition present in you or your partner that is causing this? YES or NO; If YES, please explain: ____
____
____

PERTINENT FAMILY HISTORY

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure:	______	Kidney Disease:	______	Asthma:	______	Mental Illness:	______
Stroke:	______	Bleeding Tendencies:	______	Tuberculosis:	______	Blood clots:	______
Cancer:	______	Seizures:	______	Colitis:	______	Other:	______
Emphysema:	______	Heart Disease:	______	Anemia:	______		
Ulcers:	______	Sugar Diabetes:	______	Gout:	______		

Do you have several members of the family with an inherited disease OR several members in the family with cancer? YES or NO
If YES, please explain: ____
____
____

We like to communicate with your other doctor(s) from time to time to keep them abreast of any changing medical conditions and medications as well as to send them various test and lab results. Please list all your current doctors, as appropriate.

Cardiologist: ____Gastroenterologist (GI): _________________________________

Other specialist(s): ____ Pulmonologist (lung): ___________________________________

Some patients come to our clinic for specific concerns while others prefer most of their medical needs to be performed here.

1. Will you be having your routine wellness exams with another provider? YES or NO? If so, who? _____________________
2. Do you currently keep up to date on your vaccinations? YES or NO If not, why not? _________________________________
3. If so, please list the date of your most recent:
   a. Tetanus ________ Flu ________ Pneumonia _________ Shingles __________
4. If you are under the age of 26, have you received the Gardasil or HPV vaccine series? YES or NO?
5. It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

____
Patient Signature   Date