Theresa Lerch CFNP CNM PC
320 E Broadway Jackson WY 83001

PATIENT HISTORY

Lori Bowdler FNP-BC
ph (307)733-4585 fax (307)733-4787

Name _____ DOB _____Age _____ Today's Date _____

Preferred name: _____ Pronouns: _____

Sex: Female Male Gender _____ Marital Status: Single Married Partnered Divorced Separated Other

What is the one most important symptom or concern you would like addressed today? _____

Any other concerns if time allows? _____

Urological History: Have you ever had any of the following:
□ undescended testicles □injury to the testicles □hernia □bladder or prostate surgery
Have you ever had a vasectomy? YES/NO
Do you have problems urinating, starting stream or dribbling? YES/NO

Are you sexually active? YES/NO Method of contraception: _____ What is your sexual preference? _____
Do you have any problems with sexual relations/drive? YES/NO If Yes, explain_____
Do you have a problem with achieving/maintaining erections? YES/NO
Do you have any problems with ejaculation? YES/NO
Do you have children? YES/NO
Do you have a family member with a fertility problem? YES/NO
Have you ever had any of the following Sexually Transmitted Infections? (Please circle)
Genital Herpes Chlamydia Gonorrhea HIV HPV
Are you interested in HIV/STI testing? YES/NO

Do you use any tobacco products? YES/NO
Have you used any tobacco products in the past?
Please list:
Do you drink alcohol? YES/NO
Drinks per day/week_____
Do you use recreational drugs? YES/NO

Are you satisfied with your eating habits? YES/NO
Does your weight affect your self-esteem? YES/NO
Do you binge, purge or restrict? YES/NO
Do you exercise regularly? YES/NO

Have you ever been emotionally or physically abused? YES/NO
In the past 2 weeks have you had little interest or pleasure in doing things or felt depressed or hopeless? YES/NO
Have you ever been diagnosed with a mental illness? YES/NO

Please List all medications (including supplements)_____
_____
Are you allergic to any medication(s)? YES/NO IF yes, explain_____

List any **surgery** history (Procedure and Year) _____
_____

Family History *please indicate **who and at what age** any family members diagnosed with the following:*

Diabetes _____ High Blood Pressure _____ Heart Attack _____
Stroke _____Thyroid Disease _____ Breast Cancer_____
Cancer of Uterus and or Ovaries _____ Blood Clot/Blood Disorders_____

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Seizures _____ Colon Cancer _____ Osteoporosis _____
Disordered Eating_____