The Gerald M. De Wester Treatment and Research Center

De Wester Comprehensive Evaluation Form- New Patient Part I (DCEF-NP I) ©

Please fill out the whole form; this is *essential* for performing a thorough evaluation. You may circle NONE for sections that you have no information to share (please use blue ink when possible)

Demographical information: Name: ________________________________ Date: _____________

Referred by: ____________________________________ DOB: _______________ Age: ___________

Race/ethnicity (circle all that apply; add country if known):

African American____________ Indian (India) American___________ Persian American________________
Arab American______________ Jewish American_________________ Latin American___________________
Asian American______________ Latin American__________________ Turkish American_________________
European American___________ Native American _______________ Other_________________

Religion (optional - circle):

Agnostic Hinduism Atheistic Buddhist Christian Confucianism Islamic
Native American Taoism Sikhism Other______________ Denominational branch/sect: __________

At DTRC we specialize in treatment of Sex Hormone related health concerns, including those complicated by a number of common medical problems. Indicate any of the additional health concerns listed below that you would like us to assist you with while we're addressing your sex hormones:

____Migraine Headaches
____Diabetes/diabetes prevention
____Weight loss/body composition treatment
____Cardiovascular disease (heart disease, stroke)
____Preventative Medicine
____Osteoporosis
____Chronic fatigue
____Depression/anxiety
____Metabolic syndrome
____Sexual Function
____weakness, fatigue, loss of muscle related to recent surgery, trauma, or other chronic medical disease
____Chronic Pain (in partnership with your Pain Specialist)
____Other____

Physician Use Only/HPI:____

____
____
____
____
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____

Do you desire that we send updates to your: PCP? Yes / No **Other Physician**? Yes / No **If yes, then please list contact information below and sign this consent. I authorize Jeffrey N De Wester MD to communicate freely concerning my health care with:** _________________________Signed; ____________________________________date:____/____/____

I understand that my data will be used for research purposes by DTRC, but my identity will be protected by withholding identifying information. Any utilization of my medical information that will involve possible disclosure of my identity will be done only with my prior written consent, signed: ____date:____/____/____

As a teaching institution I under stand medical science students may be participating in my care, signed: ____ date:____/____/____

Medication History/Substance Abuse History:

Drug Allergies:____

Current prescription/over the counter medications as prescribed (including vitamins and supplements):

Drug or Medication	Dosage/Frequency/date started	Condition	Effectiveness, side effects (if any)
(e.g. Prozac	20 mg. a day/2002	depression	still some depression, can't orgasm)

(See other side if more space required) **MD / NP / PA initials:** _________

 Name: ________________________________
Date: _________________________________

Medication	Dosage/Frequency/date started	Condition	Effectiveness, side effects (if any)
____________________	_______________________	____________________	______________________________
____________________	_______________________	____________________	______________________________
____________________	_______________________	____________________	______________________________
____________________	_______________________	____________________	______________________________
____________________	_______________________	____________________	______________________________
____________________	_______________________	____________________	______________________________
____________________	_______________________	____________________	______________________________

Are you taking medications as prescribed?: Y N
If no, comment:____

Symptom Review (circle any significant symptoms you have experienced in the last 3 months and place an **N** in the box following the circled symptom if it started in the last 6 months, place a **C** in the box if you have had it longer than six months; place an **L** after the circled symptom if you have experienced these for years or since childhood.)

Body Comp/ General: Weight loss [ ] Weight gain [Fatigue [ ] Excessive energy [ ] Increased central/abdominal fat [ ] Appetite changes [ ] Loss of breast volume/loss of female--"hour glass figure" [ ] "Man breasts" [ ] Poor response to diet/exercise for weight loss [ ]

Skin: Increased: looseness / wrinkling [ ] Dry / oily [ ] Changes in hair / nails [ ] Loss of: scalp/body hair [ ]

Head/neck: **Chronic or Recurring:** Sinus Pressure or pain [ ] Post Nasal Drip [ ] Sore, scratchy throat [ ] Recurring sinusitis [ ] Swollen glands [ ] Nasal stuffiness [ ] Runny nose, Sneezing, Itching eyes/ears [ ]

Respiratory: Cough [ ] Wheezing [ ] Asthma [ ] Bronchitis [ ] Pneumonia [ ] Snoring [ ] Shortness of breath [ ]

Cardiac: Chest pain: with exertion / without exertion [ ] irregular heart beat or palpitations [ ] swelling: hands feet[ ]

Urinary: Increased need to urinate [ ] Sudden urge to urinate [ ] Pain on urination [ ]
Uncontrolled loss of urine [ ] Slowing of the urinary stream [ ] Increased nighttime urination [ ]
Pain in the testicles [ ]

GYN: Irregular periods [ ] PMS [ ] Pelvic Pain [ ] Menstrual cramps [ ] Vaginal dryness [ ]
Vaginal discharge [ ] Hot flashes [ ] Breast tenderness [ ] Pain with intercourse [ ]
Have you had any unplanned vaginal bleeding in the last year or since your last visit? YES / NO If so, how many episodes, how long did they last, and how heavy was the flow? ____________________________________

Sexual function: **Problems with:** Achieving and/or sustaining erections [ ] Premature ejaculation [ ] Loss of sex drive [ ] Difficulty achieving orgasm [ ] Decreased intensity of orgasm [ ] Troubling sexual thoughts/desires [ ] Pain with intercourse [ ] Difficulty achieving clitoral engorgement and/or becoming aroused [ ]

Musculoskeletal: Muscle / joint: pains swelling stiffness [ ] Worsening arthritis pain [ ]
Joints affected: wrists elbows shoulders knees hips spine feet
Loss of muscle mass, tone, or strength [ ]

Neurologic: Numbness burning, or electrical pain [ ] Location:______________________ Memory loss [ ]
Headaches or history of Migraines [ ](circle all that apply): Age of onset ____ Have your headaches deteriorated recently? Yes / NO Aggravated by - light / sound Associated with: nausea vomiting throbbing Number of headaches per month: _________ Headaches associated with or preceded by: visual disturbance Numbness and/or weakness on one side of my body? YES / NO If so, where? _________________
My Headaches are worse: with menstrual cycles on birth control with menopause hormone treatment wine hypoglycemia sleep deprivation certain medications: ____

Hematologic: Anemia [ ] Unexplained easy bleeding/bruising [ ] History of blood clots / embolus [ ]

CNS/Psych: Depression [ ] Anxiety [ ] Panic attacks [ ] Mood swings[ ] irritability[ ] Manic episodes [ ]
Low motivation [ ] Memory loss [ ] Difficulty concentrating and/or staying on task [ ] Worsening job performance [ ] Binge eating [ ] Anorexia [ ] Bulimia[ ] Hallucinations [ ] Racing thoughts [ ]
Crying spells [ ] compulsions [ ] obsessions [ ] Antidepressants aren't effective or have lost effectiveness [ ]
My mood and/or anxiety are aggravated by(circle): my menstrual cycles hormone treatment birth control treatment menopause[ ]

Sleep: Sleep problems -- Getting to sleep Staying asleep waking up early [ ] Restless legs/arms before sleep [ ]
Snoring [ ] Pauses in breathing [ ] Going for days without need of sleep [ ] Jerking/kicking in sleep [ ]
Average number of hours a night you sleep ____hrs/night

Elaborate on any of the above if needed:____
____
Physician use:____
____
____ **MD / NP / PA initials:** _________

 Name: ______________________
Date: ______________________

Please list Meds discontinued due to lack of effectiveness or side effects or any past use of antidepressants, hormones, migraine, wt loss meds., etc.

Drug	Condition	Reason discontinued
(e.g.: Zyprexia	Bipolar	weight gain)

Substance Use: **NONE**	Last Use	Frequency (daily, wkly, etc.)	Amount Used (packs, volume, etc.)
Alcohol			
Cocaine			
IV Drug			
Marijuana			
Narcotics (i.e. Vicodin, Heroin)			
Stimulants			
Tobacco			

If you have any history of smoking, how long have you smoked ? #____ packs x _____yrs
Other:____

Drug Allergies:____
Are you allergic to tape? Yes No , **Iodine?** Yes No ***Peanuts?** Yes No **Are you on Aspirin or Blood thinner?** Yes No
If yes, are you on Coumadin (warfarin) or Plavix (circle)? If so, have you had genetic testing for sensitivity to the medicine? Yes No
Physician use:____
____
____
____
____
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____
____
____**MD / NP / PA initials:** ___________

*Prometrium

 Name: ________________________________
Date: ________________________________

Past or Ongoing Illnesses and Medical Problems: **NONE**

Check all for which you have been diagnosed and treated: Circle any you suspect you suffer from.

___allergies
___arthritis, type______________
___asthma
___bleeding disorder; Excessive bleeding after surgery/injury
___blood clots________________
___bowel obstruction
___cancer, type_______________
___colitis, type_______________
___degenerative disc disease: site_____________________
___diabetes, type_____________
___eating disorder____________
___elevated blood sugar in pregnancy
___emphysema/chronic bronchitis
___heart attack, MI; date________
___heart disease
___high blood pressure
___high cholesterol
___hyperthyroidism
___hypoglycemia
___hypothyroidism
___indigestion or ulcers from anti-inflammatory medications_________
___irritable bowel disease
___ kidney disease/stones
___migraine headaches
___narcolepsy
___obesity/weight problems
___osteoporosis
___pneumonia
___psoriasis/seborrhea
___reflux esophagitis
___restless legs
___seizures, type__________
___sinusitis (chronic)
___sleep apnea
___stroke, date___________
___testicular injury/disease:__
____
___tuberculosis
___other__________________
____
____

Physician Use:____
____

Preventative Medicine Screening Tests (date of last test, list any/abnormal findings): **NONE**

Physical exam: ____________________
Bone density: _____________________
Carotid/aortic ultrasound: ____________
CBC (blood count):_________________
Chest X-ray:______________________
Cholesterol/lipids: _________________
Coronary Calcium CT: _______
Colonoscopy: ______________
EKG: ____________________
Mammogram: ______________
Pap smear: ________________
PSA screening: ______________
Rectal/prostate exam: ________
Other: ____________________
Spirometry: _________________________
Testosterone/ estradiol levels: _________________________
Treadmill/ stress echo: ____________________________
TSH (thyroid):____________________________

Are copies of past labs/tests _____here?_____available?

Perform self ABCD mole exam? Y N
Perform monthly self breast exam? Y N
Perform monthly self testicular exam? Y N

Past Surgeries/Procedures:(when appropriate list reason/diagnosis for the procedure, date, and any abnormal findings) **NONE**

___adenoids/tonsils__________
___appendectomy
___biopsies: organ ___________
___ breast implants
___ cancer treatment, ________
___ cardiac cath_____________
___ coronary stent / balloon____
___colposcopy
___colonoscopy_____________
___coronary bypass grafts
___echocardiogram
___gall bladder removal
___gastroscopy________________
___hysterectomy______________
___infertility procedures________
___joint replacement; location__________________
___laparoscopy for treatment of:
___adhesions
___endometriosis
___ovarian cysts______________
___ovaries removed
___ prostatectomy/ TURP_________________
___sleep study, year/result:___________________
___sinus surgery________________________
___testicular surgery_______
___treadmill stress test_______
___ultrasound, site__________
___ History of previous prostate biopsy If so, list result:_______________________
____
___ Other surgeries: ______________________
____
____
____
____

Vaccines previously received: NONE: __ ever __ since last preventative exam at DTRC __ since my first visit to DTRC
(list approximate date received when possible)

___ flu __/__/__ ___H1N1 __/__/__ ___ flu/H1N1 __/__/__ ___ pneumonia __/__/__ ___ Shingles __/__/__
___ tetanus __/__/__

MD / NP / PA initials: __________

 Name: ________________________________
Date: _________________________________

Psychiatric History: **NONE**

Check those diagnoses given by a doctor: Place an X by any condition you think you may suffer from.
Past diagnosis of:

___ADD/ADHD
___alcoholism/substance abuse
___anxiety; generalized anxiety disorder
___bipolar/manic depressive illness
___bulimia/anorexia
___depression; number of episodes ____
___OCD (obsessive compulsive disorder)
___panic attacks/disorder
___physical, emotional or sexual abuse
___PMS
___postpartum depression
___PTSD
___schizophrenia
___social anxiety (SAD)/performance anxiety
___suicide attempts
___other:_______________

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Sex Hormone influence: **Have sex hormones or sex hormone treatment ever caused depression and/or anxiety symptoms or caused such symptoms to deteriorate (ie increased mood swings around your menstrual cycle) ?** Yes / No
If yes, were these symptoms ever treated with sex hormones(ie taking a birth control pill to treat PMS)? Yes / No
If yes, what treatment was prescribed and describe your reaction to the treatment ________________________________
____
If you have experienced deterioration of mood or anxiety symptoms from sex hormone influence, did the deterioration of your symptoms occur while you were already on on treatment with antidepressants? Yes / No
Please circle any circumstances that are or were associated with deterioration of your anxiety or mood symptoms: menstrual cycles irregular periods, postpartum (within 3 months of giving birth), around or during menopause, infertility treatment, treatment with hormones (ie Birth control pills, Depo-Progesterone, infertility treatment, HRT, etc), after hysterectomy

Inpatient Psychiatric/Chemical Dependency Hospitalizations (Include place and date)
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____
____
____

Any prior or current Outpatient Counseling? Y N If currently in currently in counseling, by whom and through what institution?
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____
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Physician use:____
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MD / NP / PA initials: __________

Name: ________________________________
Date: ________________________________

Hormonal/Fertility History (the portion of this section in red is mandatory for *both* men and women, black for women only):

What was the first day of your last menstrual period:____/___/____ If menopausal, when did you begin menopause? ___/___/___
How often do your periods occur?: every _______days Duration of menses: ________days Age menses began:_______
Have you even had an abnormal PAP? (list diagnosis if known)____
# of pregnancies:_____ # of births:_______ # of miscarriages/abortions: ________
# of vaginal deliveries:_______ # of cesarean sections:______ Any history of infertility? Y N
Have you undergone an hysterectomy? Yes / No Were one or both of your ovaries removed ? Yes / No

Is it currently possible for you and your mate to conceive? Y N If not, please circle reason? Hysterectomy vasectomy menopausal using contraception infertility Other: ____________________________________
If yes, are you currently trying to conceive? Y N
If not, what form of contraceptive measures are you (or spouse) taking (circle)? Pill? Condom? IUD? Diaphragm? Depoprogesterone? Other? ____

If you've ever taken" the pill" estimate the number of yrs of total use: ____yrs

List as many as you can remember of the hormone pills/vaginal rings/patches/shots/implants etc. with which you've been previously treated with for contraception (pre menopause)

Name	Type (i.e. pill, shot, implant, etc)	When utilized/how long used

Have you previously been treated with hormone replacement therapy for menopause (HRT)? Yes / No
If yes, how long after you began experiencing menopausal symptoms (or surgical removal of both ovaries) did you begin HRT? _____yrs. Since starting HRT has it ever been stopped? Yes / No If yes, how many yrs were you off HRT? ____yrs

List as many as you can remember of the different HRT hormone products with which you've been previously treated:

Name	Type (i.e. pill, shot, implant, etc)	When utilized/how long used

MD / NP / PA initials: ____________

 Name: ______________________________
Date: ______________________________

Sexual History:
Have you ever been sexually active? Y N Are you presently sexually active? Y N Are you sexually active with anyone other than your spouse / mate? Y N Please Circle your sexual orientation: heterosexual bisexual gay / lesbian uncertain
Do you have any significant questions about what constitutes healthy sexual behavior that you would like addresses? Y N
How many sexual partners have you had? ______ Have you ever had unprotected sex? Y N
Has a low sex drive and/or achieving sexual satisfaction/orgasm been a long term problem for you? Y N
History of **sexual abuse / rape**? Y N Any other form of **abuse**? Y N Do you think that **marital / relationship stress** is contributing to the sexual problems in your relationship? Y N
If so, have you discussed your **abuse / relationship stress** in therapy or with a health professional? Y N
Have you ever had a sexually transmitted disease? Y N If yes, what type:________________________________
Additional comments:____

Physician use:____

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____

Social History:
Marital Status: S M D #of children______ Education Level: HS/College/Grad./Profession__________________
Employment:____

Stressors: (Check all that apply; elaborate as needed)
___buying/moving/building house
___occupational uncertainty/stress
___relationships: death, separation, divorce
___cultural/racial
___family members' health or other stressors
___school hours/performance
___financial
___other: __________________________

Diet/Exercise History:
Circle the choice that best describes your current diet: Regular "see food" kosher low fat low cal high fat/high carb vegetarian Wt Watchers Low Carb – Atkins / South Beach other:____
List the diets you've tried in the past and the results you've had with them: ______________________________________

____

____

Type of exercise: **NONE** Running Jogging Walking Biking Swimming Aerobics
Weight lifting Pilates Yoga _______times per week

Family History:(List all biologic immediate family, parents, grandparents, aunts, uncles, with the condition.)
____Unavailable ___ **NONE KNOWN**

Family Psychiatric History	**NONE KNOWN** Mthr	Fthr	Sib(1)	Sib(2)	Sib(3)	Gfthr	Gmthr	Uncle	Aunt	Other
ADD/ADHD	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Alcohol/drug abuse	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Anxiety/panic	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Bipolar	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
OCD	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
SAD	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Psych hospitalization	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Suicide/suicide attempts*	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

Physician use:____

____

*(circle Suicide if attempt was successful)

MD / NP / PA initials: _________

 DCEF Part I (continued) Name: ________________________________
Date: ________________________________

(List all biologic immediate family, parents, grandparents, aunts, uncles, with the condition.)
____Unavailable ___ **NONE KNOWN**

General Medical:	Mthr	Fthr	Sib(1)	Sib(2)	Sib(3)	Gfthr	Gmthr	Uncle	Aunt	Other
Allergies (i.e. hay fever)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Aneurism	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Aortic	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Brain	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Arthritis (Rheumatoid)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer/Tumors :										
Brain	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Bladder	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Breast	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cervical	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Esophageal /Gastric	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Laryngeal (throat)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Lymphoma / Leukemia	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Lung	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Ovarian / Testicular	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Pancreatic / Colon	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Skin / Melanoma	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Uterine / Prostate	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other:	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Clotting Disorder	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Dementia (Alzheimer's)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes (adult onset)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Early menopause (before age 44)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Heart birth defects	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Heart disease/heart attack*	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Hemachromatosis (excess iron)	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
High blood pressure	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
High cholesterol	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Migraines	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Obesity	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Osteoporosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid disese	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

*includes anyone who has undergone: bypass surgery, stent placement, or balloon angioplasty

Physician use:____

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MD / NP / PA initials: _________