



Female New Patient Package

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-Mail Address: _____

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____
Address City State Zip

Marital Status (check one): Married Divorced Widow Living with Partner Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse's Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Social:

- I am sexually active.
- I want to be sexually active.
- I have completed my family.
- My sex has suffered.
- I haven't been able to have an orgasm.

Habits:

- I smoke cigarettes or cigars _____ per day.
 - I drink alcoholic beverages _____ per week.
 - I drink more than 10 alcoholic beverages a week.
 - I use caffeine _____ a day.
-

Medical History

Any known drug allergies: _____

Have you ever had any issues with anesthesia? () Yes () No

If yes please explain: _____

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:

- () Medical/GYN Exam in the last year.
- () Mammogram in the last 12 months.
- () Bone Density in the last 12 months.
- () Pelvic ultrasound in the last 12 months.

High Risk Past Medical/Surgical History:

- () Breast Cancer.
- () Uterine Cancer.
- () Ovarian Cancer.
- () Hysterectomy with removal of ovaries.
- () Hysterectomy only.
- () Oophorectomy Removal of Ovaries.

Birth Control Method:

- () Menopause.
- () Hysterectomy.
- () Tubal Ligation.
- () Birth Control Pills.
- () Vasectomy.
- () Other: _____

Medical Illnesses:

- () High blood pressure.
- () Heart bypass.
- () High cholesterol.
- () Hypertension.
- () Heart Disease.
- () Stroke and/or heart attack.
- () Blood clot and/or a pulmonary emboli.
- () Arrhythmia.
- () Any form of Hepatitis or HIV.
- () Lupus or other auto immune disease.
- () Fibromyalgia.
- () Trouble passing urine or take Flomax or Avodart.
- () Chronic liver disease (hepatitis, fatty liver, cirrhosis).
- () Diabetes.
- () Thyroid disease.
- () Arthritis.
- () Depression/anxiety.
- () Psychiatric Disorder.
- () Cancer (type): _____

Year: _____

BHRT Checklist For Women

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Fatigue				
Decreased sex drive/libido Sleep problems				
Mood changes/Irritability Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain Breast tenderness Vaginal dryness Hot flashes				
Night sweats				
Dry and Wrinkled Skin Hair is Falling Out Cold all the time				
Swelling all over the body Joint pain				

Family History

	No	Yes
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Signature _____ Date _____