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New Patient Questionnaire

Name: _____ Date: _____

Date of Birth _____Age _____Occupation _____

Patient History

(check all that apply)

- ☑ Fatigue and Lack of Energy
- ☐ Decreased or absent sex drive (Low Libido)
- ☐ Infrequent or absent orgasms
- ☐ I feel hopeless and without motivation
- ☐ PMS
- ☐ Dry and wrinkled skin
- ☐ Hot Flashes or Night Sweats
- ☐ Insomnia
- ☐ Change in mood: anxiety and/or depression
- ☐ Weight gain
- ☐ New Migraine Headaches
- ☐ Dry Eyes
- ☐ Declining mental ability and memory
- ☐ Diminished strength and exercise tolerance
- ☐ Muscle shrinkage
- ☐ Joints ache and/or new onset of arthritic symptoms
- ☐ Osteoporosis, osteopenia or loss of height
- ☐ New or Increased Cellulite
- ☐ Other _____

Medical History

(check all that apply)

Allergies to Medicines: _____

_____

Current Medications: _____

_____

_____

Preventive Medical Care

(check all that apply)

- ☐ Medical/GYN Exam in the Last Year
- ☐ Mammogram in last 12 months
- ☐ Bone Density in last 12 months
- ☐ Pelvic Ultrasound in last 12 months

New Patient Questionnaire (page 2)

High Risk Past Medical and Surgical History: (check all that apply)

- ☐ Breast Cancer
- ☐ Uterine Cancer
- ☐ Ovarian Cancer
- ☐ Hysterectomy with removal of ovaries
- ☐ Hysterectomy only, still have ovaries
- ☐ Blood clot or Pulmonary Embolism

Other Medical Illnesses: (check all that apply)

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart bypass surgery or stents
- ☐ Thyroid disease
- ☐ High cholesterol
- ☐ Depression/anxiety
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Cancer not listed above (type): _____Year: _____

Surgeries: None Yes (please specify below)

Type Date

_____

_____

_____

_____

Birth Control Method: **(check all that apply)**

(You must menopausal, have a hysterectomy or use birth control to be on pellet therapy)

- ☐ Menopause
- ☐ Hysterectomy
- ☐ Birth Control Pills
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Essure or Adiana (hysteroscopic sterilization)
- ☐ Other: _____

Social: **(check all that apply)**

- ☐ I have completed my family
- ☐ I have permanent Birth-control
- ☐ I am married
- ☐ I am sexually active
- ☐ I want to be sexually active

New Patient Questionnaire (page 3)

Habits: (check all that apply)

- ☐ I smoke cigarettes
- ☐ I drink more than 10 drinks of alcohol per week
- ☐ I am a recovering alcoholic
- ☐ I use or have used marijuana in the last year
- ☐ I use cocaine or other illegal drugs

Forms of Hormone Replacement I have used:

_____

_____

_____

_____

Other problems or concerns not listed in this questionnaire:

_____

_____

_____

_____

Your Goals: (check all that apply)

I am here for Hormone Pellet Therapy

I would like to talk about other forms of Bio-identical hormone replacement

Other: _____

Consent:

By beginning treatment with hormone pellet therapy, I accept all the risks of this therapy as provided to me either verbally or in writing. I accept as well that there may be future risks that have not yet been reported. I understand that sometimes higher than normal physiologic levels of hormones may be reached to create the necessary hormonal balance.

Signature: _____Date _____