

PATIENT INFORMATION SHEET

**PATIENT INFORMATION:**

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
AGE: \_\_\_\_\_ SS# \_\_\_\_\_ MARITAL STATUS: M S D W SEX: M F  
RACE: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME: \_\_\_\_\_ CELL: \_\_\_\_\_ WK: \_\_\_\_\_  
EMAIL: \_\_\_\_\_ PLACE OF EMPLOYMENT: \_\_\_\_\_  
HOW DID YOU HEAR ABOUT US: TV NEWSPAPER BILLBOARD INTERNET FRIEND/FAMILY: \_\_\_\_\_  
OTHER: \_\_\_\_\_  
EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_

**REFERRING / FAMILY PHYSICIAN INFORMATION:**

REFERRING / FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

**INSURANCE INFORMATION:**

PRIMARY INSURANCE COMPANY: \_\_\_\_\_  
ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_  
SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SS# \_\_\_\_\_  
SUBSCRIBER'S DATE OF BIRTH: \_\_\_\_\_ SUBSCRIBER'S SEX: M F  
SUBSCRIBER'S PLACE OF EMPLOYMENT: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SECONDARY INSURANCE COMPANY: \_\_\_\_\_  
ID#: \_\_\_\_\_ GROUP#: \_\_\_\_\_  
SUBSCRIBER'S NAME: \_\_\_\_\_ SUBSCRIBER'S SS# \_\_\_\_\_  
SUBSCRIBER'S DATE OF BIRTH: \_\_\_\_\_ SUBSCRIBER'S SEX: M F  
SUBSCRIBER'S PLACE OF EMPLOYMENT: \_\_\_\_\_  
RELATIONSHIP TO PATIENT: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

**INSURANCE IS NOT GUARANTEED PAYMENT. BALANCE IS DUE WITHIN 90 DAYS OF THE INSURANCE CLAIM UNLESS ARRANGEMENTS HAVE BEEN MADE THROUGH OUR OFFICE.**

**FINANCIAL AGREEMENT**

"THE INFORMATION STATED ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE. I, THE PERSON RESPONSIBLE FOR PAYMENT OF MEDICAL CARE FOR THE ABOVE PATIENT, AGREE TO PAY FOR THE OFFICE VISIT AND SERVICES THE DAY THE CARE IS PROVIDED. I AGREE TO PAY ANY BALANCE DUE ON OTHER CHARGES WITHIN 90 DAYS FROM THE DATE THAT SERVICE IS PROVIDED".

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Place Your  
Logo Here

## Female Patient Questionnaire & History

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: \_\_\_\_\_ May we contact you via E-Mail? ( ) YES ( ) NO

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased sex drive/libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood changes/Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine/severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficult to climax sexually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry and Wrinkled Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair is Falling Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold all the time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling all over the body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Family History

	NO	YES
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>