PATIENT INTAKE FORM

PATIENT INFORMATION

Name:_____ Date:_____

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

Sex: ☐ Male ☐ Female ☐ Prefer not to Share

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

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Preferred Contact Number:_____

May we send messages via text regarding appts to your cell? ☐ Yes ☐ No

Email Address:_____ May we contact you via email? ☐ Yes ☐ No

In case of emergency contact:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Primary Care Physician's Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

In the event we cannot contact you by the means you have 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 to your spouse or significant other about your treatment.

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

PATIENT HISTORY

Social:

☐ I am sexually active **OR** ☐ I want to be sexually active **OR** ☐ I do not want to be sexually active

☐ I have completed my family **OR** ☐ I have not completed my family

☐ My sex life has suffered **OR** ☐ I have not been able to have an orgasm or it is very difficult

Habits (Select all that apply):

☐ I smoke cigarettes or cigars____per day.

☐ I use e-cigarettes____a day.

☐ I use caffeine

☐ I drink alcoholic beverages____per week.

☐ I drink more than 10 alcoholic beverages a week.

PATIENT INTAKE FORM

PATIENT INFORMATION (Continued)

Drug Allergies:

Drug Allergies: ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had any issues with local anesthesia? ☐ Yes ☐ No

Do you have a latex allergy? ☐ Yes ☐ No

Medication currently taking: _____

Current hormone replacement? ☐ Yes ☐ No

If yes, what? _____

Past hormone therapy: _____

Family History (Select all that apply):

☐ Heart Disease

☐ Diabetes

☐ Osteoporosis

☐ Alzheimer's/Dementia

☐ Breast Cancer

☐ Other

Activity Level (Select all that apply):

☐ Low (Sedentary)

☐ Moderate (Walk/jog/workout infrequently)

☐ Average (Walk/jog/workout 1 to 3 times per week)

☐ High (Walk/jog/workout regularly 4+ times per week)

FEMALE HEALTH ASSESSMENT QUESTIONNAIRE

NAME: _____ EMAIL: _____

TODAY'S DATE: _____ PHONE: _____

Please mark the appropriate box for each symptom you may be experiencing.

SYMPTOMS	NONE	MILD	MODERATE	SEVERE	VERY SEVERE
Physical Exhaustion (fatigue, lack of energy, stamina or motivation)	☐	☐	☐	☐	☐
Sleep Problems (difficulty falling asleep or sleeping through the night)	☐	☐	☐	☐	☐
Irritability (mood swings, feeling aggressive, angers easily)	☐	☐	☐	☐	☐
Anxiety (feeling overwhelmed, feeling panicky, or feeling nervous)	☐	☐	☐	☐	☐
Decline in drive or interest (loss of "zest for life," feeling down or sad)	☐	☐	☐	☐	☐
Joint and muscular symptoms (joint pain, muscle weakness, poor recovery after exercise)	☐	☐	☐	☐	☐
Difficulties with memory (concentration, finding the right word, or retaining information)	☐	☐	☐	☐	☐
Vaginal dryness or difficulty with sexual intercourse	☐	☐	☐	☐	☐
Sexual Problems (change in desire, activity, orgasm and/or satisfaction)	☐	☐	☐	☐	☐
Sweating (night sweats or increased episodes of sweating)	☐	☐	☐	☐	☐
Hot Flashes (burst that starts in chest and lasts for short duration)	☐	☐	☐	☐	☐
Hair loss, thinning or change in texture of hair	☐	☐	☐	☐	☐
Feeling cold all the time, having cold hands or feet	☐	☐	☐	☐	☐
Headaches or migraines (increase in frequency or intensity)	☐	☐	☐	☐	☐
Weight (difficulty losing weight despite diet/exercise)	☐	☐	☐	☐	☐
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	☐	☐	☐	☐	☐

Other symptoms or unique health circumstances to take into consideration:

FEMALE HEALTH HISTORY & SYMPTOMS
For CDSS Continuous Round

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

PATIENT QUESTIONS

Have you been diagnosed with any cancer since initial pelleting (excluding basal cell carcinoma)? ☐ Yes ☐ No

Blood clot, DVT, heart attack or stroke since being pelleted? ☐ Yes ☐ No

Currently pregnant or trying to conceive? ☐ Yes ☐ No

Had a recent mammogram (within last 12 months)? ☐ Yes ☐ No

Have you had a hysterectomy since last insertion? ☐ Yes ☐ No

If so, type of hysterectomy: ☐ Complete (uterus and ovaries removed) ☐ Partial (uterus only removed)

Had menstrual cycle (within last 12 months)? ☐ Yes ☐ No

Had endometrial ablation? ☐ Yes ☐ No

Have you had any spotting or bleeding since last pellet? ☐ Yes ☐ No

Are you on birth control? ☐ Yes ☐ No

Name of birth control: _____

Select types of hormones you are currently on: ☐ Testosterone ☐ Estrogen ☐ Progesterone ☐ Thyroid

Are you currently on statins? ☐ Yes ☐ No

Are you a smoker? ☐ Yes ☐ No

Are you currently on oral nitrates? ☐ Yes ☐ No

PATIENT'S CURRENT AND PAST MEDICAL HISTORY

Select all that apply:

Cardiovascular Conditions:

- ☐ Tachycardia
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Obstructive Sleep Apnea
- ☐ Atrial Fibrillation

Neurological Conditions:

- ☐ Epilepsy or Seizure Disorder
- ☐ Depression/Anxiety
- ☐ Psychiatric Conditions
- ☐ Migraine with Aura
- ☐ Meningioma (since last pellet)

Gynecological Conditions:

- ☐ Pre-Menstrual Syndrome
- ☐ Endometriosis
- ☐ Fibrocystic Breast Disease
- ☐ Fibroids (since last pellet)
- ☐ Polyps (since last pellet)

FEMALE HEALTH HISTORY & SYMPTOMS
For CDSS Continuous Round

MEDICAL HISTORY

Endocrine and Metabolic:

- ☐ PCOS
- ☐ Diabetes Type 2 or Insulin Resistance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Multiple Endocrine Neoplasia Type-2

Autoimmune Conditions:

- ☐ Diabetes Type 1
- ☐ Hashimoto's Thyroiditis
- ☐ Graves' Disease
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Systemic Lupus (Erythematosus)
- ☐ Psoriasis
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

Organ Specific Conditions:

- ☐ Liver Disease (since last pellet)
- ☐ Kidney Disease (since last pellet)
- ☐ LAM (Lymphangioleiomyomatosis)
- ☐ Osteoporosis or Osteopenia
- ☐ HIV
- ☐ Hepatitis
- ☐ Hemochromatosis
- ☐ Pancreatitis (since last pellet)
- ☐ History of or Gall Bladder Disease
- ☐ Polycythemia Vera (PV)

SYMPTOMS AND CONCERNS

Select all that apply:

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Decreased Interest in Sex
- ☐ Inability To or Delayed Orgasm
- ☐ Painful Intercourse
- ☐ Urinary Incontinence
- ☐ Frequent Urinary Tract Infection
- ☐ Breast Tenderness
- ☐ Weight Gain
- ☐ Hair Loss
- ☐ Hair Thinning
- ☐ Thinning Eyebrows
- ☐ Cold Hands or Feet
- ☐ Brittle Nails
- ☐ Dry or Flaking Skin
- ☐ Lack of Energy (Fatigue)
- ☐ Decreased Muscle Mass
- ☐ Acne
- ☐ Facial Hair
- ☐ Dry Eyes
- ☐ Joint Pain
- ☐ Difficulty Sleeping
- ☐ Mind Racing at Bedtime
- ☐ Eating When Stressed