Female New Patient Intake

Patient Name: ________________ DOB: ____________ DOV: ____________

Office Use Only:

Ht: ________ in Wt: ________ lbs. Waist Circumference: _______________

BP: ________ / __________ HR: _____________ 1st Day of Last Menses: ______

Please circle the symptoms that describe what you are feeling:

Androgen deficiency symptoms:

- Fatigue
- Loss of Libido
- Loss of muscle size and tone
- Loss of muscle strength
- Loss of stamina
- Poor Quality sleep/Insomnia
- Short term memory loss or difficulty thinking
- Short term memory loss or difficulty thinking
- None

Androgen excess symptoms:

- Acne
- Excessive hair on the face and arms
- Infertility
- Mid-cycle pain
- Ovarian cysts including known polycystic ovary syndrome (PCOS)
- Thinning hair on the head
- Unstable or low blood sugar
- None

Cortisol deficiency symptoms:

- Foggy thinking
- Intolerance to exercise
- Low or intermittently low blood pressure
- Severe fatigue
- Tin and/or dry skin
- Unstable blood sugar
- Unusual pigmentation or brown spots
- None

Estrogen deficiency symptoms:

- Bladder infections
- Hot flashes

- Lethargy/fatigue
- Memory problems
- Night sweats
- Painful intercourse
- Vaginal dryness and thinning
- None

Progesterone deficiency symptoms:

- Anxiety/nervousness
- Breast tenderness/painful lumps
- Depression/mood swings
- Hypersensitivity
- Increase in headaches/migraines
- Infertility and irregular periods in pre-menopausal women
- Insomnia/restless sleep
- Irritability
- Low energy/motivation
- PMS
- Poor concentration
- Weight gain
- None

Thyroid Deficiency symptoms:

- Changes in the menstrual cycle (if menstruating)
- Constipation
- Depression
- Dry hair and hair loss/thinning
- Dry skin
- Fatigue
- Hoarseness
- Impaired memory
- Increased sensitivity to cold
- Muscle aches, tenderness and stiffness
- Muscle weakness
- Pain, stiffness or swelling in your joints
- Puffy face
- Slow heart rate
- Swelling of the thyroid gland (goiter)
- Unexplained weight gain or difficulty losing weight
- None

Female New Patient Intake

Do any of the below improve your symptoms? (Circle any that apply)

- Caffeine
- Exercise
- Sleep
- Other
- None

What is the duration of your symptoms/timing? (Circle one)

- All day or constant
- In the morning only, then improves as the day goes on
- The afternoon seems to be the worst time of day for my symptoms
- Variable

How long have the above symptoms been occurring? (Circle one)

- Less than 1 year
- Approximately 1 year
- 2-3 years
- 4-5 years
- > 5 years

How would you describe these symptoms, and their effect on your quality of life? (Circle one)

- Mild
- Moderate
- Severe

Sleep information: Please circle any pertinent symptoms below:

- Abrupt night time awakenings accompanied by shortness of breath
- Attention problems
- Difficulty going to sleep
- Difficulty staying asleep
- Episodes where someone has witnessed you stop breathing during sleep
- Excessive daytime sleepiness
- Loud snoring
- Morning headaches
- None

Female New Patient Intake

Female History: (Circle appropriate answers)

- Have you had a hysterectomy? **Yes** **No** Type: **Partial** **Total**
- Are you pregnant? **Yes** **No** Are you planning to become pregnant? **Yes** **No**
- Are you breast feeding? **Yes** **No**
- How many times have you been pregnant? ___________
- How many miscarriages have you had? ______________
- How many premature deliveries have you had? ______________
- Are you sexually active? **Yes** **No**
  - If yes, what type of contraception are you using? (Circle your method)
  - Birth control pill Tubal ligation Depo Provera Diaphragm Foam Vasectomy Condom Withdrawl method Other: ____________________
- Are you presently having problems with this birth control method? **Yes** **No**
- Date of last Pap Smear? ____
- Have you had an abnormal Pap Smear? **Yes** **No** If "yes" please explain: __________________
  ____
- Do you have any trouble with leaking urine? **Yes** **No**
- When was your last mammogram? _________________________ None
  - Was the mammogram normal? **Yes** **No** If "No" please explain: __________________
    ____
- Do you experience "PMS" symptoms around your cycle? **Yes** **No**
  - Please circle the symptoms present: bloating irritability headaches constipation fatigue
  - Do these symptoms disrupt your life and/or relationships? **Yes** **No**
  - How soon after the onset of your menses, do the symptoms resolve?
    - Circle one: < 3 days 3 days > 3 days
  - Do you have cramping with your period? **Yes** **No**
    - If yes, are they (Circle one): MILD MODERATE SEVERE
- How many days do your periods last? ______________________________
- Are your periods regular? **Yes** **No**
- How many days from the start of one period to the start of your next period? ________________
- Do you have bleeding in between periods? **Yes** **No** If so please describe: ___________________
  ____
- Have you had an endometrial ablation? **Yes** **No**
- If you no longer experience your menstrual cycle, please state why: _________________________
  ____
- Do you experience hot flashes or those associated with "menopause" symptoms? **Yes** **No**
  - If so, what do you take to relieve these symptoms? ________________________________
- Have you had a history of abnormalities with your uterus? **Yes** **No**
  - If yes, please describe: ____

Female New Patient Intake

Past Medical History: (Circle all that apply)

- Abnormal liver functions
- Acid reflux
- AIDS
- Anemia
- Anxiety (treated with medications)
- Chronic kidney disease
- Cotton seed allergy
- Depression (treated with medications)
- Diabetes type I
- Diabetes type II
- Grape seed allergy
- Hemochromatosis
- High blood pressure
- High cholesterol (treated with medications)
- High cholesterol (untreated)
- HIV
- Hyperthyroidism
- Hypothyroidism
- Inability to achieve pregnancy despite unprotected sexual relations for more than 1 year
- Obesity
- Peripheral vascular disease
- Prior HRT
- Sleep apnea (treated)
- Sleep apnea (untreated)
- Snoring
- None

Have you had any of the following cardiac disorders/events: (Circle all that apply)

- Aortic valve disorder
- Blood clot (either DVT or pulmonary embolism)
- Cardiac arrhythmia (Atrial fibrillation/flutter, Ventricular tachycardia, etc.)
- Cardiac conduction event/disorder (bundle branch block, AV block)
- Cardiomyopathy
- Coronary artery bypass graft surgery (CABG)
- Endocarditis

Female New Patient Intake

- Heart attack
- Heart failure
- Mitral valve disorder
- Pericarditis
- Stroke
- None

Past Surgical History: (circle all that apply)

- Breast augmentation
- Gastric bypass
- Gastric sleeve
- Partial or Total hysterectomy
- Other stomach surgery
- Thyroid biopsy
- Thyroid removal
- None

Past Family History: (circle all that apply)

- Breast cancer (mother or sister)
- Breast cancer (other)
- Delayed puberty
- Diabetes
- Heart attack
- Hypothyroidism
- Prostate cancer (father or brother)
- Prostate cancer (other)
- Reproductive disorder
- Stroke
- None

Marital Status: (circle one)

Married Divorced Single Widowed

What is your occupation?

____

Do you use tobacco?

- Cigarettes
- Cigars
- Dip/Snuff/Chewing tobacco
- Former smoker: When did you quit?__________(year) How much daily_______(pack)

Female New Patient Intake

Do you drink alcohol? **Yes** **No** If so, how many drinks per week? ______________________

Do you Exercise? **Yes** **No** If so how many days per week? _______________

Do you follow any particular diet? Low Glycemic Paleo Atkins Low Fat Other: _______________

When was your last comprehensive (annual) physical? _____________________

Please list any drug allergies below:

No known drug allergies or Medications allergic:_________________________________ _______
____

Please list any medications and/or supplements you are taking below:

____

Have you had or presently on hormone therapy? If you have, what type and what are the dates?

Testosterone (creams, gels, injections, pellets): ______________ DHEA: _______________

HRT Estrogen (creams, gels, pellets): ________________ Progesterone: _______________

Pregnenolone: ______________ Growth Hormone: ___________ Thyroid Hormone: ________

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ROS (Please circle all that apply)

- **Cardiovascular:** Chest pain/pressure Palpitations Pain in the lower legs with walking Fainting spells Dizziness
- ***Chest:*** Nipple tenderness Breast tenderness Breast lump/mass
- ***Constitutional:*** Abnormal weight gain Abnormal weight loss Decreased appetite Fatigue Night sweats
- ***Ear/Nose/Throat*****:** Hearing loss Ringing in ears Altered sense of smell
- **Endocrine:** Decreased sex drive Hot/cold intolerance Appetite change Excessive thirst
- ***Eyes*****:** Blurry vision Double vision Visual disturbances
- ***Gastrointestinal*****:** Swallowing difficulties Heartburn Abdominal pain Persistent nausea Vomiting
- ***Genitourinary*****:** Urinary frequency Frequent Night time urination Urinary urgency Urinary hesitancy Dribbling after urination Pain with urination Blood in urine
- ***Immune/Allergy*****:** Hives
- **Integumentary:** Suspicious skin lesions Recurrent rashes Acne
- ***Musculoskeletal*****:** Joint pain Muscle pain Muscle Weakness
- ***Neurological*****:** Frequent headaches Arm and/or leg weakness Difficulty with speech Chronic pain
- ***Psychiatric:*** Depressed mood Anxiety Irritability Insomnia Low self-confidence
- ***Respiratory:*** Persistent nonproductive cough Wheezing Shortness of breath

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Exam:

General: The patient is pleasant and well groomed who is In no acute distress.

Skin: no rashes, no lesions noted Other: ______________________________

Head: Atraumatic and normocephalic. Oro-pharynx is clear, oral mucous membranes are moist.

Other: ______________________________

Eyes: Conjunctivae and sclera are clear bilaterally.

Other: ______________________________

Ears: External ears without deformity. Canals clear bilaterally.

Other: ______________________________

Nose: Nares patent bilaterally. No masses noted.

Neck: Supple, no masses, FROM c-spine. No thyromegaly,

Other: ______________________________

Lungs:: CTA bilat with normal respiratory effort. No rales, rhonchi or wheezing.

Other: ______________________________

Heart: RRR, no murmurs, no rubs, no gallops. No edema bilat LE's.

Breast (chest): Symmetrical without discharge or deformity. No masses palpated.

GI: Soft, nontender, bowel sounds heard in all 4 quadrants and normoactive. No masses, no hepato or splenomegaly

Other: ______________________________

Extremities: Normal gait, FROM x 4 extremities with no pain. Extremities symmetric w/no joint effusions.

Other: ______________________________

Skin: Normal in color and in texture. No rashes or abnormal lesions noted.

Neuro/Psych: Appropriate affect. A&O x 3 with no evidence of agitation, or abnormal response.

Other: ______________________________

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Assessment:

Chronic Fatigue / Decreased Libido / Abnormal Weight Gain / Obesity

Sleep apnea: Reportedly stable, monitored, and treated   Sleep apnea: Poorly controlled, reevaluate

Hypothyroidism: Reportedly stable, monitored, treated   Hypothyroidism: Not well controlled

Other: ____

Plan:

Labs drawn today:

Female Standard Panel   Comprehensive Panel

Other: ____

- Pt to return for a full lab discussion with all available labs, and discussion of hormone therapy options if appropriate
- Epworth Sleep Score filled out today. The score was noted to be _____. This value is within normal limits abnormal borderline.
- Medication import history consent signed by patient.
- Medical records release form signed and authorized record release to self. at the fax number: __________________________. We will review these with the patient once they are available.
- New patient discussion information here:____
  ____
- Other: ____
  ____
- Other labs: ____ ________________________
- Other Rx written today: ____
- Discussion of low glycemic diet options and exercise modalities for optimum health and weight loss.

Signed: _____________________________________   Date: ______________