exuberan by Virtua

# Female Patient Form

| | | |
|---|---|---|
| Last Name: | First: | Middle: |
| Date of Birth: | Email Address: | Marital Status: |
| Street Address: | | |
| City: | State: | Zip Code: |
| Cell Phone: | Home Phone: | Work Phone: |
| Preferred Method of Communication: | | |
| **Emergency Contact** | | |
| Name: | Relationship: | |
| Cell Phone: | Home Phone: | |
| Are you Medicare recipient? | ☐ NO ☐ YES | ☐ PART A ☐ PART B ☐ BOTH |
| **How did you hear about Exuberan?** | | |
| ☐ Physician ☐ Friend ☐ Health care event ☐ Magazine ☐ Newspaper ☐ TV ☐ Radio | | |
| **Please check whatever symptoms may have caused you to seek Bioidentical Hormone Replacement therapy** | | |
| Mood swings | Osteoporosis/Osteopenia | Unable to achieve orgasm |
| Stress | Night sweats | Anxiety |
| Insomnia | Bloating | Migraines |
| Decreased mental clarity | Incontinence | Fatigue |
| Memory loss | Decreased energy level | Hot flashes |
| Joint pain | Vaginal dryness | Other |
| Depression | Decreased sex drive | |
| Weight gain | Decreased orgasm | |
| **What have you done to manage these symptoms in the past?** | | |
| HRT | Patches | Gels |
| Pills | Herbals | Other |
| Currently taking: | | |

**Name:**

| | | |
|---|---|---|
| Is your sex life with your partner satisfying to you? ☐ NO ☐ YES | | |
| How often you engage in sexual relations? | | |
| ☐ daily ☐ weekly ☐ bi- monthly ☐ monthly ☐ yearly ☐ not at all | | |
| Any other sexual problems ☐ yes ☐ no | Explain: | |

## Medical History

| | | |
|---|---|---|
| Are you menstruating (still have period)? | ☐ Yes ☐ No | |
| If yes, Date of LMP | | |
| If yes, identify your period cycles: | | |
| Are you currently using birth control? | ☐ Yes ☐ No | |
| If yes, what method: | | |
| ☐ Tubal ligation ☐ Vasectomy ☐ Pills ☐ Diaphragm ☐ Depo ☐ IUD ☐ Condoms ☐ Withdrawal | | |
| Have you had abnormal vaginal bleeding? | ☐ Yes ☐ No | |
| If yes, what has been done: | | |
| ☐ Ultrasound ☐ Endometrial Biopsy ☐ Ablation ☐ D&C ☐ Other | | |
| Please describe: | | |
| Have you had a pap smear within the last 2 years? ☐ Yes ☐ No | If yes, when: | |
| Have you had an abnormal pap smear? | ☐ Yes ☐ No | |
| If yes, what was done: | | |
| ☐ Repeat pap smear ☐ Colposcopy ☐ Laser surgery ☐ Cone biopsy ☐ Cryosurgery/freezing ☐ Hysterectomy ☐ Loop excision/LEEP | | |
| Have you had a mammogram within the last year? ☐ Yes ☐ No | If yes, when: | |
| If yes, what were the results? | ☐ Normal ☐ Abnormal | |
| Is there a history of breast cancer in the family | ☐ Yes ☐ No | |
| Do you suffer from Breast Pain, Leaking or Discharge? | ☐ Yes ☐ No | |
| Have you had a Bone Density Study/ Dexascan? | ☐ Yes ☐ No | |
| If yes, what were the results? | ☐ Normal ☐ Abnormal | |
| Were you ever placed on hormone replacement therapy? | ☐ Yes ☐ No | |
| If yes, what were you given, how long did you take it? | | |
| Is there a history of Sexually Transmitted Disease? | ☐ Yes ☐ No | |
| If yes, describe: | | |

**Name** _____

| Other Gyn History | | |
|---|---|---|
| **Please check and date any of the following you currently have or have had in the past.** | | |
| Uterine Fibroids | Uterine Polyps | Endometriosis |
| Breast Cancer | Ovarian Cancer | Uterine Cancer |
| Oophorectomy | Hysterectomy | |
| Tubal Ligation | Ectopic Pregnancy | |
| **Please check and date any of the following you currently have or have had in the past.** | | |
| Diabetes | Blood clot/ Bleeding problem | Stroke |
| Heart disease | High blood pressure | Thyroid disease |
| Mental health disorder | Liver disease | |
| Cancer - Specify | | |

| Past Surgical History | |
|---|---|
| List all surgeries | When |
| | |
| | |
| | |
| | |
| | |

| **Family History** | **Relation** |
|---|---|
| Breast Cancer | |
| Uterine Cancer | |
| Ovarian Cancer | |

| Medications | | |
|---|---|---|
| List all medications you are currently taking including over the counter, herbal, and supplements: | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Pharmacy Information | |
|---|---|
| Name: | Address: |
| Phone number: | Fax number: |

**Name** _____

| Allergies | |
|---|---|
| Allergies | Reactions |
| No Known Drug Allergies | |
| Latex | |
| Iodine | |
| Epinephrine | |
| Peanut | |
| Other | |

| | | |
|---|---|---|
| Do you smoke? ☐ Yes ☐ No | If yes, How long? | Packs/day |
| Do you use alcohol? ☐ Yes ☐ No | If yes, How much? | |
| Do you use recreational drugs? ☐ Yes ☐ No | If yes, Describe: | |

**Please fax or e-mail your completed forms to exuberan@virtua.org prior to your appointment.**
**Our confidential fax is 856-762-2732**