Exuberan by Virtua
106 Carnie Boulevard
Voorhees Township, NJ 08043

Today's Date:

Patient Name: Date of Birth:

Address:

Phone Number: Referring Provider:

Emergency Contact: Phone Number: Relationship:

Reason for Referral:

How Did You Hear About Us?:

Please circle whatever symptoms you are currently having to seek Bioidentical Hormone replacement Therapy:

Night Sweats	Vaginal Dryness	Hot Flashes/Flushes
Sleeping Problem	Urine Leakage with Cough/Sneeze	Decrease in Sexual Desire/Libido
Decrease in Physical Sensation During Intercourse	Pain with Intercourse	Difficulty Concentrating
Memory Loss/Foggy Thinking	Mood Swings	Migraines
Depression/Anxiety	Erectile Dysfunction	Decreased Energy Level
Muscle/Joint Pains		

Past Medical History: Please circle if you have a history of any of the following:

Diabetes	Heart Disease
High Blood Pressure	Thyroid Disease
Kidney Disease	Stroke/TIA
Liver Disease	Blood Clot/ Bleeding Problem
Mental Health Disorder	Uterine Fibroids
Endometriosis	Cancer Types (cervical, prostate, ovarian, breast, uterine)
Heart Disease	Fibrocystic Breast Disease
Disorder of Prostate	Other:

Allergies to Medications:	**Reaction:**
Latex	
Iodine	
Epinephrine	
Lidocaine	

Current Medications (Please include over the counter, vitamins, supplements)

Drug Name and Dose	**Frequency**	**Drug Name and Dose**	**Frequency**

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Surgeries:	**Date:**

Women's Health: Please provide the following information, as known.

Please indicate your menstrual status: Postmenopausal Having Periods

If you are having periods, please indicate the following information:

Date of Last Period: _____

Are they regular? Yes / No

If you are menopausal, do you still have bleeding: Yes / No

Date of last menstrual period: _____

Date of last Mammogram: _____

Location of last Mammogram: _____

Method of Birth Control: _____

Men's Health: Please provide the following information, as known.

Date of last PSA: _____

Patient Signature: Date:

Reviewed by: Date: