



New Patient's

Hi and welcome to Bioidentical Options, we are excited that you chose us to help you find Quality of Life and be the best version of yourself!

Before we get started we will need a few things. We at Bioidentical Options want to make sure you are healthy before we introduce something new to your body, so we require;

1. A current mammogram (within 1 yr) This is required annually when doing hormone therapy.
2. A Pap smear (between 2-3yrs) for most patients.
3. Labwork - We will need to know which lab you use lab corp/Quest or Christiana Care Hospital. If you have had labwork recently, please let us know to avoid duplication.

(PLEASE BE AWARE OUR SERVICES ARE THE PATIENT'S RESPONSIBILITY)

Attached you will find 2 forms that you may fill out and email back to us. We will generally get back to you within 24hours.

Looking forward to getting you scheduled soon

White Clay Creek Medical Building
550 Stanton-Christiana Rd. suite 202
Newark, De 19713
Phone: 302-225-6134
Fax:302-225-6120
email: BHRT@bioidenticaloptions.com.

PLEASE CALL THE OFFICE WITH MEDICAL CONCERNS

NEW PATIENT QUESTIONNAIRE

Name: _____ Today's Date: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Email Address: _____

How did you hear about us? Patient Name: _____ Other: _____

In Case of Emergency Contact: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____ Work: _____

If you move forward with pellet therapy, do you prefer to sign a paper or electronic consent? Electronic Paper

MEDICAL HISTORY

Height: _____ Weight: _____ Last Menstrual Period: _____ Hysterectomy? () No () Partial () Full

Do you smoke? () Yes () No () Quit How much? _____ How often? _____ Age started? _____

Do you drink alcohol? () Yes () No () Quit How much? _____ How often? _____ Age started? _____

Any known drug allergies: () Yes () No If yes please explain: _____

Current Medications and dosage: _____

Nutritional/Vitamin Supplements: _____

Current Hormone Replacement Therapy: _____ Past HRT: _____

Surgeries, list all and Year: _____

Other Pertinent Information: _____

Do you have a personal history of? Check all that apply.

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
() Prostate Cancer

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: _____

PRINT NAME

SIGNATURE

DATE

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. ***Please mark only ONE box.***

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1. Hot flashes, sweating (episodes of sweating)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Irritability (feeling nervous, inner tension, feeling aggressive)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Anxiety (inner restlessness, feeling panicky)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet? Yes No **Do you have daily bowel movements?** Yes No

Do you have gas, bloating or abdominal pain after eating? Yes No

Please select your WEEKLY Activity Level based on this criteria → *Physical activity that accelerates heart rate / Breathlessness*

0-1 day per week (Low) 2-3 days per week (Average) More than 3 days per week (High)

Please list any prior hormone therapy?

FOR OFFICE USE ONLY

CHART ID: _____ **DOB:** _____ **APPT DATE:** _____