bioTE® MEDICAL

NEWELLNESS

Patient Name:_____ **Patient Identifier:**_____

Patient Information

Please complete the following information in preparation for your consultation.

Date:_____
Street address:_____ Date of Birth:_____ Age:____
City, State, Zip:_____ Sex:____Male ____Female
Phone:_____(home/work) Race:___Caucasian ___African American
Cell:_____ ___Asian ___Native American
Email:_____ ___Hispanic ___Other_____
Weight:_____ Height:___feet_____inches

Doctor's Name:_____ Address._____ Phone_____
_____
_____
_____

Medication Allergies._____ Reaction_____
_____
_____
_____

Social History
Marital Status: ___Single ___Married ___Partnered ___Separated ___Divorced ___Widowed
Exercise:_____Minutes _____Times per week
Caffeine:_____Cups/day
Alcohol:_____Drinks/week
Tobacco:_____Packs/day for ____years (____current or quit ___ years/months ago)
Illicit Drugs: _____
Occupation: _____

Social (continued):

( ) I am sexually active.
( ) I want to be sexually active.
( ) I have completed my family.
( ) My sex has suffered.
( ) I haven't been able to have an orgasm.

Family History
Please indicate next to each condition whether family member is **G**randparent, **F**ather **M**other, **S**ister, or **B**rother.

___Cancer ___Diabetes ___High Cholesterol ___High Blood Pressure
___Depression ___Heart Attack ___Kidney Disease ___Stroke
___Mental Illness ___Lung Disease ___Asthma

Other:_____

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Past Surgical History

___ Appendectomy ___ Angioplasty ___CABG (Bypass) ___Gall Bladder Removal
___Knee ___ Hip ___ Pacemaker ___Other:_____

Hysterectomy: ( ) **YES** ( ) **NO** **Ovaries removed:** ( ) **YES** ( ) **NO**

___Number of children

Past Medical History

___Cancer	___Diabetes	___High Cholesterol	___High Blood Pressure
___Depression	___Heart Disease	___Kidney Disease	___Stroke
___Mental Illness	___Lung Disease	___Asthma	___Ulcers
___Gout	___Thyroid Dis.	___Irregular Heart Beat	___Rheumatoid Arthritis
___Fibroids	___TB	___Low blood sugar	___Painful Heel
___Gallstones	___GERD/Reflux	___Other(s):_____	

___ Heart Disease/or Heart attack
___ Blood Clot or Pulmonary embolism
___ Arrhythmia
___ Any form of Hepatitis
___ HIV
___ Lupus or other auto immune disease _____
___ Fibromyalgia
___ Fibrocystic breast disease
___ Osteoarthritis
___ Anxiety
___ Psychiatric Disorder.
___ Cancer (type): _____
Year: _____

Birth Control Method:

( ) Menopause.
( ) Tubal Ligation.
( ) Birth Control Pills.
( ) Other: _____ Hysterectomy (year) _____

_____ Irregular cycles _____ Heavy menstruation
_____ Date of last period_____ Amount of days _____ Normal, Heavy or Light? _____

Other menstrual Disorder: _____

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Preventative Medical Care:

( ) Medical/GYN Exam in the last year.
( ) Bone Density in the last 12 months.
( ) Pelvic ultrasound in the last 12 months.

Last Mammogram (date): _____ **Normal: ( ) YES ( ) NO**
Last Pap (date): _____ **Normal: ( ) YES ( ) NO**

Vaccination History (Month/Year)
_____Flu _____Pneumonia _____Shingles _____Tetanus _____Other:_____

Current Medications
Please include all prescribed, over-the-counter, supplements, herbals, and/or botanicals

Name and Strength	How Prescribed	Indication	For How Long	Prescribing Doctor
Ex: Lipitor 40mg	1 tab daily	High Cholesterol	Over a year	Dr. Bay Conn

NEWELLNESS

BHRT CHECKLIST FOR WOMEN

Name:_____ Date: _____

Symptoms (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Sleep problems				
Mood changes/Irritability				
Migraine/Severe headaches				
Swelling all over the body				
Tension				
Bloating				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Hair loss				
Fatigue (Tiredness)				
Memory loss				
Mental confusion				
Decreased sex drive/Libido				
Difficult to climax sexually				
Weight gain				
Joint pain				

Any changes in your personal history: Yes No

If yes, please explain: _____

Any changes in medications: Yes No

If yes, please explain: _____

Last Menstrual Period_____

Other symptoms that concern you:_____

_____

Personal/Family History	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		