Aesthetics & Weightloss

New Patient Hormones: ***Female***

Patient Name:_____ Date:_____

DOB:_____ Age:_____ Height:_____ Weight:_____

Race:_____ Date of Last Menstrual Period:_____ Number of Pregnancies_____

Number of Live Births:_____ Abortions/Miscarriages:_____

History of Renal Disease: Yes / No

Active Liver Disease: Yes / No

History of Breast Cancer: Yes / No *If yes: (self or family)*

History of Cervical Cancer: Yes / No

History of Ovarian Cancer: Yes / No

Hysterectomy: Yes / No Year:_____

Acne: Yes / No

Facial Hair: Yes / No

Hair Loss: Yes / No

History of PCOS: Yes / No

History of Heavy Menses/Fibroids: Yes / No

History of Metabolic Syndrome: Yes / No

Pre-Menopausal: Yes / No

Menstrual Migraines: Yes / No

Difficulty Losing Weight: Yes / No

Fibrocystic Breast Disease: Yes / No

OB/GYN Physician:_____

Previously Received Hormone: Yes / No

Date of Last PAP:_____

If yes, Where:_____

Year of Last Mammogram:_____

Date:_____

Pellets: Yes / No

TO BE COMPLETED BY PHYSICIAN

Current Labs: Date_____ FSH Level:_____ Testosterone Level: _____ Estradiol Level:___

Previous Estrogen Dose:_____ **Previous Testosterone Dose:_____**

Problem Factors:_____

Date:_____ Pellet # _____ (Right / Left) Estrogen:_____ Testosterone:_____

Booster Injection: Estrogen:_____ Testosterone:_____ (Right / Left)

Physician/Practitioner Signature:_____

***Follow-up labs to be collected at: ____A&W, ____OBGYN Office, Other:_____