

NEW PATIENT (Female)
BioTE HEALTH ASSESSMENT FORM



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Lawrenceville, GA 30043
contact@sugarloafwellnesscenter.com

INSTRUCTIONS:

Complete this form BEFORE your initial consultation with your doctor. You may print then fill the form or complete the fillable form fields then print your form.

Email your completed form to:
Lakeisha.Davis@priviamedicalgroup.com

Name: _____ Date of Birth: _____

FEMALE HEALTH ASSESSMENT

Which of the following symptoms apply to you currently (in the last 2 weeks)? Please mark the appropriate box for each symptom. For symptoms that do not currently apply or no longer apply, mark "none".

Symptoms	Never (0)	Mild (1)	Moderate (2)	Severe (3)	Very Severe (4)
Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweating (night sweats or increased episodes of sweating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems (difficulty falling asleep, sleeping through the night or waking up too early)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressive mood (feeling down, sad, on the verge of tears, lack of drive)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability (mood swings, feeling aggressive, angers easily)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (inner restlessness, feeling panicky, feeling nervous, inner tension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical exhaustion (general decrease in muscle strength or endurance, decrease in work performance, fatigue, lack of energy, stamina or motivation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems (change in sexual desire, sexual activity, orgasm and/or satisfaction)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder problems (difficulty in urinating, increased need to urinate, incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal symptoms (sensation of dryness or burning in vagina, difficulty with sexual intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint and muscular symptoms (joint pain or swelling, muscle weakness, poor recovery after exercise)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties with memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with thinking, concentrating or reasoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty learning new things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble thinking of the right word to describe persons, places or things when speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase in frequency or intensity of headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss, thinning or change in texture of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel cold all the time or have cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or difficulty losing weight despite diet and exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry or wrinkled skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total score	_____				

Severity Score: Mild: 1-20 / Moderate: 21-40 / Severe: 41-60 / Very severe: 61-80



Name: _____ Date of Birth: _____

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Preferred Contact Number: _____

May we send messages via text regarding appointments to your cell? YES NO

Email Address: _____ May we contact you via email? YES NO

In Case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Care Physician's Name: _____ Phone: _____

Address: _____

Marital Status (check one): Married Divorced Widow Living with Partner Single

In the event we cannot contact you by the means you have provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below, you are giving us permission to speak with your spouse or significant other about your treatment.

Social:

- I am sexually active. OR I want to be sexually active. I do not want to be sexually active
- I have completed my family. OR I have NOT completed my family.
- My sex life has suffered. OR I have not been able to have an orgasm or it is very difficult.

Habits:

- I smoke cigarettes or cigars ___ per day. I use e-cigarettes ___ a day I use caffeine ___ a day.
- I drink alcoholic beverages ___ per week. I drink more than 10 alcoholic beverages a week.

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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Female Medical History

Any known drug allergies: _____

Have you ever had any issues with local anesthesia? Yes No

If yes, please explain: _____ Do you have a latex allergy? Yes No

Medications Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Surgeries, list all and when: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

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.

Pertinent Medical/Surgical History:

- Breast cancer
- Uterine cancer
- Ovarian cancer
- Polycystic ovaries/PCOS
- Acne
- Excess facial/body hair
- Infertility
- Endometriosis
- Epilepsy or seizures
- Fibrocystic breast or breast pain
- Uterine fibroids
- Irregular or heavy periods
- Menstrual migraines
- Hysterectomy with removal of ovaries
- Partial hysterectomy (uterus only)
- Oophorectomy removal of ovaries only

Birth Control Method:

- Menopause
- Hysterectomy
- Tubal ligation
- Birth control pills
- Vasectomy
- IUD
- Infertility
- Other _____

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FEMALE PATIENT QUESTIONNAIRE & HISTORY CONTINUED

Medical Illnesses:

- | | | |
|---|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Any form of hepatitis or HIV | <input type="checkbox"/> Chronic liver disease
(hepatitis, fatty liver, cirrhosis) |
| <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Lupus or other autoimmune
disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Frequent blood donation or
history of anemia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Hair thinning | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Chronic kidney disease | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Stroke and/or heart attack | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Psychiatric disorder |
| <input type="checkbox"/> Blood clot, DVT and/or
a pulmonary embolism | | <input type="checkbox"/> Cancer (type): _____ |
| <input type="checkbox"/> Heart arrhythmia or atrial
fibrillation | | Year: _____ |



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POST-INSERTION INSTRUCTIONS FOR WOMEN

- Your insertion site has been covered with two layers of bandages. Remove the outer pressure bandage any time after 24 hours. It must be removed as soon as it gets wet. The inner layer (usually a steri strip) should be removed in 3 days.
- **Do not take tub baths or get into a hot tub or swimming pool for 3-4 days.** You may shower tomorrow, however.
- No heavy lifting or major exercises for the incision area for the next 3-4 days, which includes running, elliptical, squats, lunges, etc.
- The sodium bicarbonate in the anesthetic may cause the site to swell for 1-3 days.
- The insertion site may be uncomfortable for up to 2 to 3 weeks. If there is itching or redness you may take Benadryl for relief (25 to 50 mg orally every 6 hours). Caution: this can cause drowsiness!
- You may experience bruising, swelling, and/or redness of the insertion site which may last from a few days up to 2 to 3 weeks.
- You may notice some pinkish or bloody discoloration of the outer bandage. This is normal.
- If you experience bleeding from the incision, apply firm pressure for 5 minutes.
- Please call if you have any bleeding not relieved with pressure (not oozing), as this is NOT normal.
- Please call if you have any pus coming out of the insertion site, as this is NOT normal.

REMINDERS:

- **Remember to have your post-insertion blood work done 6 weeks after your FIRST insertion.** If you are not feeling any better by 4 weeks, however, please call the office to have your labs drawn early.
- Most women will need re-insertion of their pellets 3-4 months after their initial insertion. If you experience symptoms prior to this, please call the office.
- Please call as soon as symptoms that were relieved from the pellets start to return to make an appointment for your next insertion.

ADDITIONAL INSTRUCTIONS:

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM.

Print Name: _____

Signature: _____

Date: _____