PATIENT INTAKE FORM

PATIENT INFORMATION

Name:_____ Date:_____

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

Sex: ☐ Male ☐ Female ☐ Prefer not to Share

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

Home Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Preferred Contact Number:_____

May we send messages via text regarding appts 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 Phone:_____

Primary Care Physician's Name:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

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 to your spouse or significant other about your treatment.

Name:_____ Relationship:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

PATIENT HISTORY

Social:

☐ I am sexually active **OR** ☐ I want to be sexually active **OR** ☐ 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 (Select all that apply):

☐ I smoke cigarettes or cigars____per day.

☐ I use e-cigarettes____a day.

☐ I use caffeine

☐ I drink alcoholic beverages____per week.

☐ I drink more than 10 alcoholic beverages a week.

PATIENT INTAKE FORM

PATIENT INFORMATION (Continued)

Drug Allergies:

Drug Allergies: ☐ Yes ☐ No

If yes, please explain: _____

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

Do you have a latex allergy? ☐ Yes ☐ No

Medication currently taking: _____

Current hormone replacement? ☐ Yes ☐ No

If yes, what? _____

Past hormone therapy: _____

Family History (Select all that apply):

☐ Heart Disease

☐ Diabetes

☐ Osteoporosis

☐ Alzheimer's/Dementia

☐ Breast Cancer

☐ Other

Activity Level (Select all that apply):

☐ Low (Sedentary)

☐ Moderate (Walk/jog/workout infrequently)

☐ Average (Walk/jog/workout 1 to 3 times per week)

☐ High (Walk/jog/workout regularly 4+ times per week)