BIOTE FEMALE HEALTH HISTORY & SYMPTOMS

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

PATIENT QUESTIONS

Currently pregnant or trying to conceive? ☐ Yes ☐ No

Date of last mammogram: _____

Had menstrual cycle (within last 12 months)? ☐ Yes ☐ No

Date of last menstrual cycle: _____

Had endometrial ablation? ☐ Yes ☐ No

Is the patient on birth control? ☐ Yes ☐ No Name of birth control: _____

Has the patient had a hysterectomy? ☐ Yes ☐ No

If so, type of hysterectomy: ☐ Complete (uterus and ovaries removed) ☐ Partial (uterus only removed)

Is the patient currently utilizing BHRT or HRT? ☐ Yes ☐ No

If yes, select types of Hormones: ☐ Testosterone ☐ Progesterone ☐ Estrogen ☐ Thyroid

List Name and Dose of Hormone(s): _____

Is the patient currently on statins? ☐ Yes ☐ No

Is the patient a smoker? ☐ Yes ☐ No

Is the patient currently on oral nitrates? ☐ Yes ☐ No

MEDICAL HISTORY

Select all that apply:

Cardiovascular Conditions:

☐ Heart Attack or Stroke (within last 6 months)

☐ DVT or Blood Clot (within last 6 months)

☐ Hypertension

☐ Hyperlipidemia

☐ Obstructive Sleep Apnea

☐ Atrial Fibrillation

☐ Tachycardia

Gynecological Conditions:

☐ Pre-Menstrual Syndrome

☐ Endometriosis or History of Endometriosis

☐ Fibrocystic Breast Disease

☐ Fibroids or History of Fibroids

☐ Polyps or History of Endometrial Polyps

Cancer:

☐ Breast Cancer or History of Breast Cancer

☐ Endometrial Cancer

☐ Cervical Cancer

☐ Ovarian Cancer

☐ Thyroid Cancer or History of Thyroid Cancer

☐ Meningioma

☐ Except for Basal Cell Carcinoma any Other Cancers?

Neurological Conditions:

☐ Epilepsy or Seizure Disorder

☐ Depression/Anxiety

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MEDICAL HISTORY

Endocrine and Metabolic:

- ☐ PCOS
- ☐ Diabetes Type 2 or Insulin Resistance
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Multiple Endocrine Neoplasia Type-2

Autoimmune Conditions:

- ☐ Diabetes Type 1
- ☐ Hashimoto's Thyroiditis
- ☐ Graves' Disease
- ☐ Rheumatoid Arthritis
- ☐ Multiple Sclerosis
- ☐ Systemic Lupus (Erthematosus)
- ☐ Psoriasis
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

Organ Specific Conditions:

- ☐ Liver Disease or History of Liver Disease
- ☐ Kidney Disease or History of Kidney Disease
- ☐ LAM (Lymphangioleimyomatosis)
- ☐ Osteoporosis or Osteopenia
- ☐ HIV
- ☐ Hepatitis
- ☐ Hemochromatosis
- ☐ Pancreatitis or History of Pancreatitis
- ☐ History of or Gall Bladder Disease

SYMPTOMS AND CONCERNS

Select all that apply:

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Vaginal Dryness
- ☐ Decreased Interest in Sex
- ☐ Inability To or Delayed Orgasm
- ☐ Painful Intercourse
- ☐ Urinary Incontinence
- ☐ Frequent Urinary Tract Infection
- ☐ Breast Tenderness
- ☐ Weight Gain
- ☐ Hair Loss
- ☐ Hair Thinning
- ☐ Thinning Eyebrows
- ☐ Cold Hands or Feet
- ☐ Brittle Nails
- ☐ Dry or Flaking Skin
- ☐ Lack of Energy (Fatigue)
- ☐ Decreased Muscle Mass
- ☐ Acne
- ☐ Facial Hair
- ☐ Dry Eyes
- ☐ Joint Pain
- ☐ Difficulty Sleeping
- ☐ Mind Racing at Bedtime

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