Birken
MEDICAL AESTHETICS

FEMALE PATIENT QUESTIONNAIRE & HISTORY

Name: _____ Today's Date: _____
(Last) (First) (Middle)

Birthdate: ___/___/___ Age: _____ Wt: _____ Ht: _____ Occupation: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____
May we contact you via E-Mail? ( ) YES ( ) NO

In Case of Emergency Contact: _____ Relationship: _____

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

Primary Care Physician's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy Name : _____ Phone: _____

Marital Status {check one}: ( )Married ( )Divorced ( )Widow ( )LivingwithPartner ( )Single

In the event we cannot contact you by the mean's you've 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.

Spouse's Name: _____ Relationship: _____

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

Randy A. Birken, MD

4185 Technology Forest Blvd. Suite 190, The Woodlands, TX 77381 | Phone: 281.419.3231 | Fax: 832.813.7462

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Social:

( ) 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.

Habits:

( ) I smoke cigarettes or cigars _____ per day.

( ) I drink alcoholic beverages _____ per week.

( ) I drink more than 10 alcoholic beverages a week.

( ) I use caffeine _____ a day.

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FEMALE PATIENT MEDICAL HISTORY

Surgeries, list all and when: _____

Any known drug allergies: _____

Have you ever had any issues with anesthesia? ( ) Yes ( ) No

If yes please explain: _____

Medications/Dosage Currently Taking: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Nutritional/Vitamin Supplements: _____

Last menstrual period (estimate year if unknown): _____

Other Pertinent Information: _____

Preventative Medical Care:
( ) Medicai/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

High Risk Past Medical/Surgical History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy - removal of ovaries

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Vasectomy
( ) Other: _____

Medical Illnesses:
( ) High blood pressure
( ) Heart bypass
( ) High cholesterol
( ) Hypertension
( ) Heart Disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary emboli
( ) Arrhythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other auto immune disease.
( ) Fibromyalgia
( ) Trouble passing urine or take Flomax or Avodart
( ) Chronic liver disease (hepatitis, fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression/anxiety
( ) Psychiatric Disorder
( ) Cancer (type): _____ Year: ____

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BHRT CHECKLIST FOR WOMEN

Name: _____ Date: _____

E-Mail: _____

Symptom (please check mark):	Never	Mild	Moderate	Severe
Depressive Mood	○	○	○	○
Memory Loss	○	○	○	○
Mental Confusion	○	○	○	○
Decreased Sex Drive/Libido	○	○	○	○
Sleep Problems	○	○	○	○
Mood Changes/Irritability	○	○	○	○
Tension	○	○	○	○
Migraine/Severe Headaches	○	○	○	○
Difficult to Climax Sexually	○	○	○	○
Bloating	○	○	○	○
Weight Gain	○	○	○	○
Breast Tenderness	○	○	○	○
Vaginal Dryness	○	○	○	○
Hot Flashes	○	○	○	○
Night Sweats	○	○	○	○
Dry and Wrinkled Skin	○	○	○	○
Hair is Falling Out	○	○	○	○
Cold all the time	○	○	○	○
Swelling All Over the Body	○	○	○	○
Joint Pain	○	○	○	○

Family History	No	Yes
Heart Disease	○	○
Diabetes	○	○
Osteoporosis	○	○
Alzheimer's Disease	○	○
Breast Cancer	○	○

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