**HRT Patient Data Sheet (Male)**

|  |  |
| --- | --- |
| **Full Name** Click here | **Date of Birth D)** 00 **(M)** 00 **(Y)** 0000 **Age:** 00 **y.o** |
| **E-mail** Click here |
| **Address** Click here | **Phone No.** Click here |
| **Mobile No.** Click here |
| **Occupation**Click here | **Nationality**Click here | **Weight**Click here | **Height**Click here | **Blood Type**Click here |

**Please fill-in the blanks or check your most appropriate response:**

1. What major symptom(s) or problem(s) brought you in for consultation?

* Kindly check all that apply:

[ ]  Increased sensitivity to cold /

warmth (Night sweats)

[ ]  Excessive sweating

[ ]  Difficulty in falling asleep

[ ]  Sleep disturbance

[ ]  Irritability / Mood swings

[ ]  Anxiety / General unease

[ ]  Excessive sleepiness

[ ]  Easy-fatigability

[ ]  Memory loss

[ ]  Dizziness

[ ]  Chest palpitations

[ ]  Chest pain

[ ]  Frequent headaches

[ ]  Neck & shoulder stiffness

[ ]  Back ache

[ ]  Joint pain

[ ]  Cold & clammy hands and/or

feet

[ ]  Limb numbness

[ ]  Sound hypersensitivity

[ ]  Wrinkles / Skin sagging

[ ]  Muscle weakness

[ ]  Weight gain / Weight loss

[ ]  Loss of libido / poor sex drive

[ ]  Erectile dysfunction

[ ]  Infertility

[ ]  Enlarging breasts

[ ]  High predisposition to Colds /

Flu

[ ]  Urinary leakage

[ ]  Constipation

[ ]  Brittle fingernails / toenails

[ ]  Hair loss / Brittle hair

[ ]  Others: Click here

2. When did you start having the symptom(s)?

3. Has it been treated previously? [ ]  YES [ ]  NO

4. Do you sleep well? [ ]  YES [ ]  NO (Hours of sleep: 00)

5. Do you smoke cigarettes / tobacco? [ ]  YES [ ]  NO

* If YES, No. of cigarettes / day: 00, No. of years: 00

6. Do you exercise, play any sports, or are physically active? [ ]  YES [ ]  NO

* If YES, how often? 00 times / week

7. Do you drink alcoholic beverages? [ ]  YES [ ]  NO

* If YES, No. bottles / week: 00, Type of drinks: Click here

8. Does anyone in your family have any serious medical disease? (ex: Cancer, Heart Disease, Diabetes Mellitus, etc.)

 [ ]  YES [ ]  NO

* If YES, what disease(s)? Click here

9. Why are you interested in Hormone Replacement Therapy? Click here

10. Do you have any existing / current medical condition(s)? [ ]  YES [ ]  NO

* If YES, what disease(s)? Click here

11. Have you undergone any type of surgery (including cosmetic surgery)? [ ]  YES [ ]  NO

12. Have you undergone any type of anesthesia (i.e.: Topical, Local, General, Dental)? [ ]  YES [ ]  NO

* If YES, did you experience any adverse effects from the anesthesia? [ ]  YES [ ]  NO
	+ - If YES, which symptom(s) describe what happened?

[ ]  Itchiness

[ ]  Nausea

[ ]  Sudden drop / increase in blood-pressure

[ ]  Dizziness

[ ]  Difficulty in breathing

[ ]  Chest tightness/pain

[ ]  Swelling

[ ]  Others: Click here

13. Do you have a history of any previous medication-related allergy? [ ]  YES [ ]  NO

* If YES, kindly provide the necessary details by checking the drug name below and writing down allergic reaction (ie: drug/medicine name and allergic reaction)

[ ]  Penicillin – Click here

[ ]  NSAIDS (Ibuprofen, Mefenamic Acid, etc) –

 Click here

[ ]  Pyrines – Click here

[ ]  Aspirin – Click here

[ ]  Unrecalled antibiotics –

 Click here

[ ]  Others: Click here

14. Do you have any other allergies? [ ]  YES [ ]  NO

* If YES, kindly check all that applies:

[ ]  Pollen

[ ]  Bronchial Asthma

[ ]  Atopic Dermatitis (Skin Allergy)

[ ]  Allergic Rhinitis

[ ]  Allergic Conjunctivitis

[ ]  Seafood

[ ]  Nuts

[ ]  Others: Click here

15. Does your skin form Keloid scars after wound healing? [ ]  YES [ ]  NO

16. Are you currently taking any prescription medication(s) or supplement(s)? [ ]  YES [ ]  NO

* If YES, kindly specify: Click here

17. Have you undergone any form of physical examination within the past 6 months? [ ]  YES [ ]  NO

* If YES, was further medical evaluation or additional tests recommended? [ ]  YES [ ]  NO

18. Have you ever been diagnosed with any major health problem or pre-existing medical condition in the past?

 [ ]  YES [ ]  NO

* If YES, kindly check all that applies:

[ ]  Cardiovascular (High blood-pressure | Angina | Heart disease/CVD | Others: Click here)

[ ]  CNS & HEENT (Encephalitis or Meningitis | Stroke/CVA | Hyperhidrosis | Tonsillitis | Others: Click here)

[ ]  Pulmonary (Bronchial Asthma | COPD | Pneumonia | Tuberculosis | Others: Click here)

[ ]  Gastro-Intestinal (Peptic Ulcer | GERD | Hyperacidity | Stomach cancer | Others: Click here)

[ ]  Hepatobiliary ( Liver infection or Hepatitis | Gallstones | Fatty liver | Others: Click here)

[ ]  Reproductive (Myoma | Ovarian cysts | Hormonal imbalance | Others: Click here)

[ ]  Breast (Breast cancer | Mastitis | Breast Cyst or benign tumor | Others: Click here)

[ ]  Musculoskeletal (Osteopososis | Scoliosis | Others: Click here)

[ ]  Endocrine & Rheumatic (Diabetes Mellitus | Thyroid disease | Lupus | Rheumatoid Arthritis | Gout |

 Others: Click here)

[ ]  Other diseases: Click here

* If you have encircled any of the items above, are you still receiving treatment for said condition?

[ ]  YES [ ]  NO

19. Have you ever received any blood transfusion? [ ]  YES [ ]  NO

20. Do you currently have any infectious or communicable disease? [ ]  YES [ ]  NO

21. Do you have any other concern(s) apart from today’s consultation? [ ]  YES [ ]  NO

* If YES, kindly check all that apply

[ ]  Body odor

[ ]  Excessive sweating or

Hyperhidrosis

[ ]  Laser hair removal

[ ]  Hair growth for Balding

[ ]  Age spots

[ ]  Freckles

[ ]  Wrinkles

[ ]  Acne and Acne scars

[ ]  Large pores

[ ]  Broken spider capillaries

[ ]  Mole removal

[ ]  Birthmarks

[ ]  Scar removal (ex: Keloid)

[ ]  Sagging / Loose skin

[ ]  Laser face lift

[ ]  Skin rejuvenation and

 Revitalizing Injections

[ ]  Skin Whitening

[ ]  Glutathione + Vit. C IV

[ ]  Body Contour and Slimming

[ ]  Cellulite treatment

[ ]  Dermatological counselling

[ ]  Others: Click here

22. Would you like to join our mailing list for exclusive promos, special campaigns, and updates? [ ]  YES [ ]  NO

* If YES, which mailing method(s) would you prefer? (Check all that apply)

[ ]  Direct Mail (Monthly Newsletter)

[ ]  E-mail (Monthly Newsletter)

23. How did you get to know about Azabu Skin Clinic?

[ ]  Friend / Family / Officemate Referral

[ ]  Magazine Ad ([ ]  EURObiz [ ]  Tokyo Metropolis [ ]  iNTOUCH [ ]  Philippine Digest)

[ ]  Online Website:

* + ([ ]  PC [ ]  Mobile )
	+ ([ ]  Banner Ad [ ]  Google Search [ ]  Yahoo Search [ ]  Safari [ ]  Facebook

 [ ]  Others: Click here)

* + - If through searching, what key words did you use? Click here to enter text.

 [ ]  Others: Click here