**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