**HRT Patient Data Sheet (Female)**

|  |  |
| --- | --- |
| **Full Name (**[ ]  **Ms. /** [ ]  **Mrs. )**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

[ ]  Hot flashes (face & upper body)

[ ]  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

[ ]  Pain during / after sexual

 intercourse

[ ]  Vaginal dryness / itching

[ ]  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)? Click here

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 (ie: drug/medicine name and allergic reaction)

[ ]  Penicillin

[ ]  NSAIDS (Ibuprofen, Mefenamic Acid, etc)

[ ]  Pyrines

[ ]  Aspirin

[ ]  Unrecalled antibiotics

[ ]  Others: Click here

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

* If YES, kindly check all that apply

[ ]  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 encircle all that apply

[ ]  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. Are you in menopause? [ ]  YES [ ]  NO

* If YES, at what age did you have your last menstrual period? 00 years old

(Questions 22-25 are for menstruating patients)

22. When was the first day of your last menstrual period? (Day) 00 (Month) 00 (Year) 0000 (No. days) 00

23. Is your menstrual cycle regular or monthly? [ ]  YES [ ]  NO (Every 00 days)

24. Do you experience mid-cycle spotting / irregular heavy bleeding? [ ]  YES [ ]  NO

25. Are you currently pregnant? [ ]  YES [ ]  NO

 Do you have plans to get pregnant in the future? [ ]  YES [ ]  NO

 Are you currently breastfeeding? [ ]  YES [ ]  NO

26. Have you been pregnant and given birth? [ ]  YES [ ]  NO

* If YES, at what age? (00 years old)
* If YES, which method? [ ]  Normal Spontaneous Delivery [ ]  Cesarean Section
* If YES, did you breastfeed? [ ]  YES [ ]  NO

27. 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 & Slimming

[ ]  Cellulite treatment

[ ]  Dermatological counselling

[ ]  Others: Click here

28. 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)

29. 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

 [ ]  Others: Click here