Exuberan® by Virtua
106 Carnie Boulevard
Voorhees Township, NJ 08043

Today's Date:

Patient Name: Date of Birth:

Address:

Phone Number: Referring Provider:

Emergency Contact: Phone Number: Relationship:

Reason for Referral:

Reason for Today's Visit / Present Symptoms:

Please circle whatever symptoms you are currently having to seek Bioidentical Hormone replacement Therapy:

Night sweats	Vaginal Dryness	Hot flashes/flushes
Sleeping problem	Urine leakage with cough/sneeze	Decrease in sexual desire
Decrease in physical sensation during intercourse	Pain with intercourse	Difficulty concentrating
Memory loss/foggy thinking	Mood swings	Migraines
Depression	Anxiety	Decreased energy level
Muscle/joint pains		

Past Medical History: Please circle if you have a history of any of the following:

Diabetes	Heart disease
High blood pressure	Thyroid disease
Kidney disease	Stroke/ TIA
Liver disease	Blood clot/ Bleeding problem
Mental health disorder	Uterine fibroids
Endometriosis	Cancer types (cervical, prostate, ovarian, breast, uterine)
Heart disease	Fibrocystic breast disease
Disorder of prostate	

Allergies to Medications:	**Reaction:**
Latex	
Iodine	
Epinephrine	
Lidocaine	

Current Medications (Please include over the counter, vitamins, supplements)

Drug Name and Dose	**Frequency**	**Drug Name and Dose**	**Frequency**

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Surgeries:	**Date:**

Do you exercise? Yes / No

If yes, how often? _____

Women's Health: Please provide the following information, as known.

Please indicate your menstrual status: Postmenopausal Having Periods

If you are having periods, please indicate the following information:
Date of Last Period: _____
Are they regular? Yes / No

If you are menopausal, do you still have bleeding: Yes / No
Date of last menstrual period: _____

Date of last mammogram _____

Location of last mammogram: _____

Men's Health: Please provide the following information, as known.

Date of last PSA: _____

Patient Signature: Date:

Reviewed by: Date: