Date: _____

Name: _____ DOB: _____ Age: _____

Phone Number: _____ Email Address: _____

I am interested in:

_____ **BIO-IDENTICAL HORMONE THERAPY REPLACEMENT**

Have you done hormone replacement before? Y / N Currently on: Y / N

If currently on it, what type of therapy: ____ OTC ____Creams ____ Orals ____ Patches ____ Pellets

If you are currently on pellet therapy, why are you leaving: _____

_____

List any past therapies you have done: ____ OTC ____Creams ____ Orals ____ Patches ____ Pellets

Have you had a hysterectomy: Y / N Ovaries removed: Y / N

Have you had a uterine ablation: Y / N Tubes Tied: Y / N

Do you currently have cycles: Y / N Are they regular: Y / N Are they heavy: Y / N

Do you have an IUD: Y / N

_____ **VAGINAL REJUVENATION**

What type of symptoms are you having?

___ Stress Urinary Incontinence (Leakage when cough, sneeze, lifting etc)

___ Laxity

___ Dryness

___ Desire

How did you hear about us?

___ Google

___ Facebook

___ Physician _____

___ Friend: _____

___ Prior Patient