Chris A. Pate, MD

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(919) 988-9332 Fx(919) 581-0353

265 Racine Drive, Suite 102
Wilmington, NC 28403
(910) 399-6661 Fx(910) 399-6667

Personal Data

Name		Date
Address	City State	Zip
Home Phone	Work/Cell Phone	Date of Birth
Employer	Emergency Contact	Phone
Email	Marital Status ☐Married ☐ Single	

Primary Care Physician

Name	Phone/Fax Number	
Address	City State	Zip
Pharmacy Name	Phone/Fax Number	
How did you hear about us?		

Present Symptoms

Please briefly describe your symptoms.

What do you feel is the most important factor to your present symptoms?

BioSymmetry HORMONE HEALTH

Name: ________________________

Past Medical History

Date	Medical diagnosis, illness, accident

Past Surgical History

Date	Surgery

Social History

Please remember that this information is strictly confidential and will be used **only** to address you symptoms and/or complaints.

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- Are you currently a smoker? _________
- If yes, how many packs per day? ___________
- How many total years have you smoked?___________

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what type of alcohol (beer, wine, spirits ect.) do you have in an average week? ____

Family History

Please list ALL illness(heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, skin, prostate, lung, blood), ect. If a member is deceased, please list age of death and cause if known.

Relationship	**Age**	**Medical Problem(s)/ Cause of Death**
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

BioSymmetry
HORMONE HEALTH

Name: ____________________________

Medications: Please list ALL prescription medications. Include ALL over the counter medications, supplements, and vitamins.		
Name of Medication	Dosage	Dosing schedule

Allergies Are you allergic to any MEDICATIONS (Prescription or OTC)

Gynecological History

Date of last PAP smear? ___________________ Physician who performed?_____________________

Physician's Phone Number: __________________________

Date of last mammogram? ________________ Facility where performed: _______________________

Facility Phone Number: _____________________________

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have ______________________________		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have? _____________________________		
Have you ever had a breast biopsy?		
How many breast biopsies (positive or negative) have you had?		
Have you had at least one breast biopsy with atypical hyperplasia?		
Do you have a medical history of any breast cancer or of ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or have received radiation therapy to the chest for treatment of Hodgkin lymphoma?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes?		
Have you noticed any lumps in your breasts?		
Have you been tested & been told you have the BRAC1 or BRAC2 gene, or a diagnosis of a genetic syndrome that may be associated with increase risk of breast cancer?		

 BioSymmetry HORMONE HEALTH Name: ___________________________

	YES	NO
Are you still having menstrual periods? If yes, when was the first day of your last period?		

What was your age at the time of your 1st menstrual cycle? ___________________________________

Please describe any problems you have with your periods:

____

Periods are (were): ☐ regular ☐ irregular ☐ Painful ☐ crampy ☐ heavy ☐ light ☐ other

Age periods began: ________ # days of bleeding: ___________ cycle length (days): ______

If you are no longer having periods, at what age did your periods stop? ______________________
If your periods stopped less than one year ago, how many months ago was your last period? ______

Did your periods stop because you had a hysterectomy? ☐ Yes ☐ No

- If yes, what was the reason for the surgery? ____
- Were the ovaries removed at the same time? ☐ Yes ☐ No ☐ Not sure

Do you have a history of any of the following cancers?

☐ Vulva ☐ Ovary ☐ Other: ____
☐ Uterus ☐ Fallopian Tube
☐ Vagina ☐ Breast ____
☐ Cervix ☐ Colon

What was your age at the time of your first live birth of a child? _______________________________

How many of your first-degree relatives -mother, sister, daughters- have had breast cancer? ______

What is your race/ethnicity? ____

a. What is the sub race/ethnicity? (other that white or African American _____________________

Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Weight:_________________	Height:__________________

Present Symptoms

Name: ______________________________

Estrogens

Check which of these symptoms are troublesome and have persisted over time

Estrogen Deficiency	Estrogen Excess/Progesterone Deficiency	
☐ Hot Flashes	☐ Mood Swings (PMS)	☐ Uterine Fibroids
☐ Night Sweats	☐ Cystic Ovaries	☐ Weight Gain – Hip Area
☐ Vaginal Dryness	☐ Tender Breast	☐ Bleeding Changes
☐ Foggy Thinking	☐ Heavy Menses	☐ Elevated Triglycerides
☐ Memory Lapses	☐ Water Retention	☐ Breast Cancer
☐ Urinary Incontinence	☐ Sugar Craving	☐ Low Libido
☐ Tearful	☐ Nervousness	
☐ Depressed	☐ Irritable	
☐ Sleep Disturbances	☐ Anxious	
☐ Heart Palpitations/Arrhythmia	☐ Fibrocystic Breast	
☐ Bone Loss	☐ Headaches	
☐ Headaches	☐ Cold Body Temperature	

Androgens

Check which of these symptoms are troublesome and have persisted over time

Androgen Excess	Androgen Deficiency	
☐ Increased Facial Hair	☐ Low Libido	☐ Sleep Disturbances
☐ Increased Body Hair	☐ Vaginal Dryness	☐ Apathy/Decreased Passion for Life
☐ Acne	☐ Fatigue	☐ Decreased Muscle Mass
☐ Oily Skin	☐ Aches/Pains	☐ Heart Palpitations/Arrhythmia
☐ Nervous	☐ Memory Lapses	☐ Headaches
☐ Irritable	☐ Foggy Thinking	☐ Fibromyalgia
☐ Anxious	☐ Urinary Incontinence	☐ Irritable
☐ Breast Cancer	☐ Depressed	☐ Thinning Skin
☐ Ovarian Cysts	☐ Anxious	
☐ Elevated Triglycerides	☐ Bone Loss	
☐ Sleep Disturbances		

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess		Thyroid Deficiency	
☐ Heat Intolerance	☐ Irritable	☐ Cold Intolerance	☐ Aches/Pains
☐ Heart Palpitations/Arrhythmia		☐ Constipation	☐ Hair Loss
☐ Weight Loss		☐ Fatigue/Weakness	☐ Muscle Weakness
☐ Tremors/Shakiness		☐ Unexplained Weight Gain	☐ Muscle Cramps
☐ Diarrhea		☐ Inability to Lose Weight Gain	☐ Stress
☐ Nervousness/Anxious/Panic Attacks		☐ Cold Body Temperature	☐ Coarse Dry Skin
☐ Insomnia		☐ Lack of Motivation	
☐ Difficulty Conceiving/Infertility		☐ Voice has become hoarse	

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the clinic or provider listed below to release my protected health information to the clinic or provider indicated as the authorized recipient.

Clinic or Provider releasing records: ____

Address: ____

Phone: ________________________________ Fax: _________________________________

****

Patient: ____

DOB: ____

Please release my medical records to the following authorized recipient:

☐ Biosymmetry, PC
2280-B Hwy 70 West
Goldsboro, NC 27530
Phone: 919-988-9332 Fax: 919-581-0353

☐ Biosymmetry, PC
265 Racine Drive, Suite 102
Wilmington, NC 28403
910-399-6661 Fax: 910-399-6667

☐ Other: ____
____
____

Dates of Treatment/Service to be released: ☐ All dates available
Or the following specific date: ______________________

Type of information to be released:

☐ Pap report, Mammogram report (Most recent) ☐ Other: __________________________

Reason for disclosure: ____

Please do not release the following information, even if occurring during dates above:
____

This authorization will automatically expire in 90 days from the date of your signature, or fulfillment of the record release request. This Authorization may be revoked at any time by the patient or authorized representative in writing.

I understand that this information may include any history of acquired immunodeficiency syndrome (HIV or AIDS), sexually transmitted diseases, psychiatric care, and treatment for substance abuse, or similar sensitive information. I am aware that I may refuse to sign this authorization. I further understand that I have the right to inspect any protected health information to be disclosed.

I understand that Biosymmetry assumes no responsibility for the use or misuse by others of my protected health information. I have had the opportunity to discuss any concerns about the privacy of my protected health information and to discuss Biosymmetry's privacy policy.

Federal law states that treatment, enrollment or eligibility for benefits may not be conditioned upon obtaining this authorization, if such conditioning is prohibited by the Privacy Rule. Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient.

______________________________	___________________________	____________
Patient's Signature	Patient's Name	Date
______________________________	___________________________	____________
Parent, Guardian, or Representative	Name	Date