Chris Pate, MD

2280 Hwy 70 West, Suite B
Goldsboro, NC 27530
(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	Social Security #
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

- 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)

Urological History

Date of last prostate exam? ___________________ Physician who performed? _____________________

Physician's Phone Number: __________________________

	YES	NO
Have you ever had an abnormal prostate exam? If yes, what was the abnormality and what follow up did you have ______________________________		
Have you ever had an elevated PSA? If yes, what was the abnormality and what follow up did you have? _____________________________		
Have you ever had a prostate biopsy?		

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

- ☐ Lung
- ☐ Breast
- ☐ Colon
- ☐ Prostate
- ☐ Skin
- ☐ Lymphoma
- ☐ Leukemia
- ☐ Other: ____

____

	Yes	No	Not Sure
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you have difficulty urinating?			
Have you ever had kidney problems?			

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

Name: ___________________________

Present Symptoms

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	

Adrenals

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

Cortisol Excess		Cortisol Deficiency
☐Sleep Disturbances	☐ Heart Palpitations	☐ Fatigue
☐ Bone Loss	☐ Headaches	☐ Sugar Cravings
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight Gain – Waist	☐ Cold Body Temperature	☐ Chemical Sensitivity
☐ Loss of muscle mass	☐ Sugar Cravings	☐ Stress
☐ Thinning Skin	☐ Low Libido	☐ Cold Body Temperature
☐ Elevated Triglycerides	☐ Hair Loss	☐ Irritable
☐ Breast Cancer	☐ Increased Facial Hair	☐ Arthritis
☐ Irritable	☐ Increased Body Hair	☐ Heart Palpitations
☐ Anxious	☐ Acne	☐ Aches/Pains
☐ Memory Lapses	☐ Nervous	

Weight: ____________________ Height: _____________________