THE BIO BALANCE CENTER for Women
HORMONE REPLACEMENT THERAPY

CLINIC USE

HN / file no.

Received

Reviewed by

PATIENT INTAKE FORM

Women's pre-treatment intake

About 6 minutes. Symptom sections tell you which time frame to answer for. Your physician reviews your answers alongside your lab results and goes over them with you at your consultation, in the clinic or by LINE or WhatsApp voice call.

8 sections · 6 minutes | Completely confidential | Bangkok or Pattaya

How to return this form: fill it in on your computer, save it, then upload the saved file on the Patient Intake page of our website. Prefer your phone? Use the online form on the same page.

Men: please use the men's intake form.

Bangkok +66 97-240-5686 (phone / WhatsApp) · LINE @maximumbangkok | Pattaya +66 82-988-3515 (phone / WhatsApp) · LINE @maximumpattaya

Fields marked * are required.

1 About you

Basic contact and demographics.

Full name *

Date of birth (DD/MM/YYYY) *

Phone / WhatsApp *

LINE ID

Email *

Preferred language

○ English ○ Thai ○ Other

Preferred clinic *

○ Bangkok ○ Pattaya ○ Either / not sure

Height (cm)

Weight (kg)

Waist at navel (cm), optional

What made you book this consultation?

2 Safety and lab essentials

So we can prescribe safely. All answers are confidential.

Have you ever had any of the following? Check all that apply.

- ☐ Breast cancer
- ☐ Blood clot (DVT/PE) or a clotting disorder
- ☐ Migraine with aura
- ☐ Diabetes or prediabetes
- ☐ Depression or anxiety currently treated
- ☐ Uterine (endometrial) or ovarian cancer
- ☐ Heart attack, stent, bypass, or stroke
- ☐ Liver or gallbladder disease
- ☐ Unexplained vaginal bleeding
- ☐ None of the above

If heart attack / stent / bypass / stroke, year

Current medications and supplements (name and dose)

Drug allergies (name and reaction)

☐ No known drug allergies

Do you take blood thinners?

○ Yes ○ No

For each, answer Never / Past / Current.

Estrogen (any form)	○ Never	○ Past	○ Current
Progesterone or progestin	○ Never	○ Past	○ Current
Testosterone or DHEA	○ Never	○ Past	○ Current
Birth control pill, hormonal IUD, implant or injection	○ Never	○ Past	○ Current
Thyroid medication	○ Never	○ Past	○ Current
Growth hormone or peptides	○ Never	○ Past	○ Current
GLP-1 medication (semaglutide, tirzepatide)	○ Never	○ Past	○ Current

If currently using hormones: product, form (pill, patch, gel, cream, injection, pellet) and date of last dose

Periods and pregnancy

Which describes you now? *

○ Regular periods ○ Irregular periods ○ No period for 12+ months ○ Periods stopped after surgery or treatment

First day of last period (or age at last period)

Uterus removed (hysterectomy)?

○ Yes ○ No

Ovaries removed?

○ No ○ One ○ Both

Are you pregnant or breastfeeding? *

○ Yes ○ No

Do you want to have children in the future?

○ Within 12 months ○ Eventually ○ No ○ Unsure

Last mammogram (month / year)

Last Pap smear or HPV test (month / year)

About your blood test (if you have one)

Fasting

○ Yes ○ No

Time of draw

Day of your cycle when drawn (day 1 = first day of period)

☐ Not applicable

3 Sexual health

Answer for the past 4 weeks. Skip anything you'd rather discuss with your doctor.

Sex drive compared with 5 years ago

○ Higher ○ Same ○ Lower ○ Much lower

Vaginal dryness in daily life

○ Never ○ Rarely ○ Sometimes ○ Often ○ Always

0 = No sexual activity · 1 = Almost never · 2 = A few times · 3 = Sometimes · 4 = Most times · 5 = Almost always

During sex, how often are you adequately lubricated?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5
How often is intercourse uncomfortable or painful?	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5

How often are you able to reach orgasm? ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

How often is sex satisfying for you? ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4 Urinary

0 = Never · 1 = Rarely · 2 = Sometimes · 3 = About half the time · 4 = Often · 5 = Almost always

Leaking urine when you cough, laugh, or exercise ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Urgent need to urinate that is hard to delay ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Leaking before you reach the toilet ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Times you get up at night to urinate ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

5 Menopause symptoms, mood and energy

Over the past 2 weeks.

0 = Not at all · 1 = Several days · 2 = More than half the days · 3 = Nearly every day

Hot flashes ○ 0 ○ 1 ○ 2 ○ 3

Night sweats ○ 0 ○ 1 ○ 2 ○ 3

Little interest or pleasure in doing things ○ 0 ○ 1 ○ 2 ○ 3

Feeling down, depressed, or hopeless ○ 0 ○ 1 ○ 2 ○ 3

Feeling anxious or irritable ○ 0 ○ 1 ○ 2 ○ 3

Low energy or fatigue ○ 0 ○ 1 ○ 2 ○ 3

Low drive or motivation ○ 0 ○ 1 ○ 2 ○ 3

Poor concentration, memory, or brain fog ○ 0 ○ 1 ○ 2 ○ 3

Joint or muscle aches ○ 0 ○ 1 ○ 2 ○ 3

Thinning hair, dry skin, or new facial hair or acne ○ 0 ○ 1 ○ 2 ○ 3

Have others commented that you seem more irritable, withdrawn, or less social?

○ Yes ○ No

6 Sleep

Average hours of sleep per night

Sleep quality (1 very poor – 10 excellent)

Do hot flashes or night sweats wake you up?

○ Yes ○ No

Do you snore loudly, or has anyone seen you stop breathing during sleep?

○ Yes ○ No ○ Not sure

Do you often feel sleepy during the day?

○ Yes ○ No

7 Exercise and lifestyle

Resistance training (days per week)

Cardio (days per week)

Strength and recovery compared with 2 to 3 years ago

○ Better ○ Same ○ Worse

Eating pattern

○ Mixed ○ High-protein ○ Low-carb / keto ○ Intermittent fasting ○ Vegetarian / vegan ○ Other

Alcoholic drinks per week

Nicotine (smoke or vape)

○ Never ○ Former ○ Current

8 Goals

Pick up to 3 that matter most.

Your top 3 goals (choose up to 3)

- ☐ Energy
- ☐ Sleep
- ☐ Libido and sexual comfort
- ☐ Fat loss
- ☐ Skin and hair
- ☐ Healthy aging
- ☐ Hot flash and night sweat relief
- ☐ Mood and motivation
- ☐ Mental sharpness
- ☐ Muscle, strength and bone
- ☐ Regular cycles / PMS
- ☐ Fertility

What would you most like to be different in 6 months?

Anything else we should know?

☐ **I confirm this information is accurate. I consent to the clinic collecting and using my health information for my medical evaluation and care, as described in our Privacy Policy (on our website) and in line with Thailand's Personal Data Protection Act (PDPA). ***

Patient signature

Date

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