



## Hormone Replacement Therapy Paperwork

In order to help determine if you are a good candidate for hormone replacement therapy treatments, please fill in the information below to the best of your ability.

Today's Date: \_\_\_\_\_

Legal Name : \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Sex:  Female  Male

Race:  White  African American  Hispanic  Other: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

\*Email(required): \_\_\_\_\_

*\*Email is used for secure patient portal communication, online scheduling, and electronic statements.*

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you give us permission to contact this person in the event of an emergency?  Yes  No

How did you hear about our office? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

May we contact your doctor with our findings?  Yes  No

### Medical History

Have you ever taken hormone replacement medications?  Yes  No If yes, when and name the medication? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Personal/Family History (check all that apply):

- Deep Vein Thrombosis(DVT)
- Stroke within last 6 months
- Prostate Cancer
- Blood Clotting Disorder
- Uterine Cancer
- Heart Attack within the last 6 months
- High Blood Pressure
- Other: \_\_\_\_\_
- Pulmonary Embolism
- Breast Cancer
- Heart Disease

Do you have any children?  Yes  No      Are you wanting any children in the future?  Yes  No

For Women:

Are you currently pregnant/breastfeeding?  Yes  No      Are you taking birth control?  Yes  No

Do you have a regular menstrual cycle?  Yes  No

**Symptoms**

Please check all that apply:

- Depression                       Fatigue                       Body Aches                       Loss of Muscle
- Lack of Sexual Desire               Muscle Pains               Unstable Mood               Hot Flashes
- Vaginal Dryness                       Urinary Incontinence

**Medications**

Please list all medications you are currently taking including prescription, over-the-counter, botanicals, homeopathic, and supplements:

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**Allergies**

Please list any and all allergies: \_\_\_\_\_

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**Consultation for Regenerative and Medical Services**

I understand that my initial consultation is complementary and is used to determine whether or not I am a candidate for care. There will be a one-on-one consultation with the Doctor to:

- ❖ Review my case history to determine if the practice may be able to help me;
- ❖ Review my dietary and nutritional habits, nutritional supplements, herbs, minerals, botanicals, homeopathics, ect and discuss my problems and answer questions.

The only cost I may incur is the cost of any initial screening tests the Doctor requests, that I choose, to undergo.

I am aware that after the consultation, I may not be accepted as a patient or additional testing may be recommended prior to treatment. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand and accept the terms of the complimentary consultation.

**Patient Name(Print):** \_\_\_\_\_

**Patient Signature(X):** \_\_\_\_\_ **Date:** \_\_\_\_\_

I acknowledge and agree to the **Patient Health Information Consent Form.\***

I acknowledge and agree to the **Missed Appointment Policy** including the **\$50** missed appointment fee.\*

*\*Policies are available on the clipboard for review.*

**Patient/Parent/Guardian Signature(X):** \_\_\_\_\_ **Date:** \_\_\_\_\_