



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 Assigned at Birth: ☐ Female ☐ Male

Race: ☐ White ☐ African American ☐ Hispanic ☐ Other: _____

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____

Social Security Number: _____

*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) | ☐ Uterine Cancer | ☐ Pulmonary Embolism |
| ☐ Stroke within last 6 months | ☐ Heart Attack within the last 6 months | ☐ Breast Cancer |
| ☐ Prostate Cancer | ☐ High Blood Pressure | ☐ Heart Disease |
| ☐ Blood Clotting Disorder | ☐ Other: _____ | |

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:

ALLERGIES

Please list any and all allergies: _____

PHI/MISSED APPOINTMENT POLICY

I acknowledge and agree to the **Patient Health Information Consent Form**, and I confirm that all of my questions have been answered.*

I acknowledge and agree to the **Missed Appointment Policy**, including the **up to \$75** missed appointment fee.*

**Policies are available on the clipboard or upon request at any time for review.*

Patient Signature(X): _____ **Date:** _____

COMPLIMENTARY CONSULTATION ACKNOWLEDGMENT

I understand that my initial consultation is complimentary and is intended to determine whether I may be a candidate for care at this practice. During my one-on-one consultation, the Doctor may:

- Review my case history to determine whether this practice may be able to assist with my health concerns.
- Review my dietary and nutritional habits, including nutritional supplements, herbs, minerals, botanicals, homeopathic products, and other relevant products or therapies.
- Discuss my health concerns and answer questions related to my case.

I understand that the consultation itself is provided at no charge. The only costs I may incur during the initial consultation process are for screening tests recommended by the Doctor that I voluntarily elect to undergo. Any applicable costs will be explained to me before I proceed.

I understand that following the consultation, I may not be accepted as a patient, or additional testing may be recommended before care can be considered. Regardless of whether I am accepted as a patient, I may request a copy of any laboratory results.

I agree to complete all required paperwork fully and truthfully to the best of my knowledge.

I understand that I am encouraged to communicate with my other healthcare providers regarding all aspects of my healthcare, including any care I receive at this office.

By signing below, I acknowledge that I have read and understood this information and agree to the terms of the complimentary consultation.

Patient Name(Print): _____

Patient Signature(X): _____ **Date:** _____