Today's Date: _____/_____/_____ Wellness Intake (Male clients disregard related female questions)

Please fill out and send back to me before getting labs drawn.

**(BHRT = Bioidentical Hormone Replacement Therapy)

Patient Name: ____ Birth date: _____/_____/_____

Address: ____

City: ____ State: _______ Zip: _______

Phone: ____ Email: ___________________

Martial Status _____ Married _____ Single _____ Widowed

Occupation ____________________

Height: _______ Weight: ________

Allergies: Please check all that apply

_____ Penicillin _____ morphine _____ dye allergies _____ Codeine

_____ aspirin _____ nitrate allergy _____ sulfa drugs _____ food allergies

_____ pet allergies _____ seasonal (pollen) allergies other: ________________

Please describe the allergic reaction you experienced.

____

____

____

Doctor's Name: Address: Phone:

____________________________ ____ ______________

____________________________ ____ ______________

____________________________ ____ ______________

____________________________ ____ ______________

How did you arrive at the decision to consider bio-identical hormone replacement (BHRT)?

______ Doctor _____ Self _____ Friend/family member _____ Other

Current Prescription Medications/Current Nutritional Supplements:

(Please bring any nutritional supplements you take to your consultation)

Name Strength Date Started How often per day

____

____

____

____

____

____

____ __

____ __

Over-the-counter (OTC) issues: Please check all products that you use once or more per month.

_____ pain reliever

_____ sleep aids

_____ antidiarrheal

_____ Laxative / stool softener

_____ Diet aids / weight loss products

_____ antacids

_____ others: ___________________

How often and how much? ____

Do you use tobacco? _____ Yes _____ No __________________________________

Do you use alcohol? _____ Yes _____ No __________________________________

Do you use caffeine? _____ Yes _____ No __________________________________

Hormones previously taken Date Started Date Stopped Reason

____

____

____

____

Have you ever used oral contraceptives? ____ Yes _____ No

If yes, any problems using oral contraceptives? ____ Yes _____ No

Please describe:

____

____

Have you had any of the following tests performed in the last year?

Please check all that apply and note date

Normal:

Mammogram ⁅No ⁅Yes Date: ___________ ⁅Yes ⁅No

Pap Smear ⁅ No ⁅Yes Date: ___________ ⁅Yes ⁅No

When was your last cycle or first day of last cycle? _________________________

How many days did it last? _________________________

Do you have, or have you ever had Premenstrual Syndrome (PMS)? ___ No ___ Yes

If yes, please explain symptoms:

____

____

____

Since you first began having menses, have you ever had what YOU would consider to be abnormal cycles?

_____ No _____ Yes

If yes, please explain your symptoms and at what age(s) this occurred:

____

____

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? _____ No _____ Yes

Have you had a hysterectomy? _____ No _____ Yes (date of surgery) ___________

Ovaries removed? _____ No _____ Yes

Have you had a tubal ligation? _____ No _____ Yes

Medical Conditions / Diseases: Please circle all that apply to you or an immediate family member and mark if self or family.

Allergies Alzheimer's Arthritis Asthma

Cancer: __________

Clotting Problems Depression Diabetes Eczema Fibrocystic breast

Ulcers Anxiety Disorder Stroke

Other: ___________

Heart Disease High Cholesterol or Lipids High Blood Pressure Eye Disease

Migraines/headaches Osteoporosis Thyroid Disease Ulcer

Emphysema/COPD Fibromyalgia GERD Seizure Disorder

Irritable Bowel

Other: __________

Other: __________

Please indicate your symptoms for the following conditions by using the following numeric scale:

0 being no symptoms at all up to 5 being the worst symptoms imaginable

Fibrocystic Breast 0 1 2 3 4 5

Weight Gain 0 1 2 3 4 5

Heavy/Irregular menses 0 1 2 3 4 5

Hot Flashes 0 1 2 3 4 5

Dry Skin / Hair 0 1 2 3 4 5

Anxiety 0 1 2 3 4 5

Depression 0 1 2 3 4 5

Night Sweats 0 1 2 3 4 5

Vaginal Dryness 0 1 2 3 4 5

Headaches 0 1 2 3 4 5

Irritability 0 1 2 3 4 5

Mood Swings 0 1 2 3 4 5

Breast Tenderness 0 1 2 3 4 5

Sleep Disturbances/Insomnia 0 1 2 3 4 5

Fluid Retention 0 1 2 3 4 5

Breakthrough Bleeding 0 1 2 3 4 5

Fatigue 0 1 2 3 4 5

Memory Loss 0 1 2 3 4 5

Incontinence/frequent urination 0 1 2 3 4 5

Arthritis 0 1 2 3 4 5

Difficulty reaching orgasm 0 1 2 3 4 5

Decreased libido 0 1 2 3 4 5

Hair Loss 0 1 2 3 4 5

Indigestion 0 1 2 3 4 5

Cold hands/feet 0 1 2 3 4 5

Diarrhea and/or constipation 0 1 2 3 4 5

Erectile Dysfunction 0 1 2 3 4 5

Failed morning erections 0 1 2 3 4 5

Urinary Retention 0 1 2 3 4 5

Urinary Frequency (nighttime especially) 0 1 2 3 4 5

What are your goals with taking BHRT / Wellness Testing?

____

____

____

____

Please write down any specific questions you have about BHRT / Wellness Testing.

____

____

____

Name (please print): ____

Signature: ______________________________________ Date: ___________________________