New BHRT Patient- Women's Intake Form

Patient Name: (Last) (First) (MI)

_____

Patient Address: _____ City: _____State: _____Zip:_____

Phone Number: _____Email: _____

Birthdate: _____Age: _____ Sex: M F

Occupation: _____

In Case of Emergency:

Name: _____ Relationship: _____

Phone: _____

How did you hear about us? _____

Are you under the care of a qualified healthcare professional? Please list whom. *

_____

As detailed in the Consent portion, it is highly recommended that you are under the care of a qualified healthcare professional, who has verified that it is safe for you to exercise and be on a weight loss program and is monitoring medications and any health concerns that you list here (besides your weight issues- that's what we're covering). If you are on medications (particularly for high blood pressure, heart issues, or diabetes), you will need these to be monitored during and after the program as your need for them may change. *

I acknowledge the above statement above. Sign: _____

Reason for Visit:

Menopausal Symptoms
Hormone Imbalance
Sexual Dysfunction
Vaginal Symptoms/Pain
Sexual concerns
Weight loss program
Other

Do you have a primary care provider and an OB/GYN?

Yes
No

Name of PCP
Name of OB/GYN

Do you see any specialists? If so, name and reason below

Months since last visited PCP

Less than 1
1 to 6
7 to 12
More than 12 months

Months since last visited OB/GYN

Less than 1
1 to 6
7 to 12
More than 12 months

Medication name, dosage and frequency (including supplements and birth control)

Medication allergies

Currently on Hormone Replacement Therapy or Birth Control?
Yes
No
If yes, name and dosage

Have you ever been told NOT to use hormone replacement therapy?
If so, why?

Have you had any of the following?

Heart attack	High blood pressure
Stroke	Liver disease
Pulmonary embolism	High triglycerides/cholesterol
DVT	Undiagnosed vaginal bleeding
Any clotting disorders	Bleeding after menopause
Breast cancer	Uterine fibroids
Uterine/endometrial cancer	Porphyria

Month and year of last Pap smear and result

Last Mammogram & Result (If over 40)

Last Menstrual Period **Frequency?** **Length?**

Personal History of Breast Cancer
Yes
No
1st Degree Family (Mother, Sister, Daughter) History of Breast Cancer
Yes
No

Medical History/Problems

Surgical History

Smoking Status
Current/former/never

Planning pregnancy in next 12 months?

Fitness activities

Description of diet and any nutritional concerns

Anything else patient would like to share