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HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

Name:_____ Date of Birth:_____ Age: _____ Sex: ☐ Female ☐ Male

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Work Phone:_____ Email:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

How did you hear about this clinic? ☐ Social Media:_____ ☐ Referral:_____
☐ Internet Search ☐ Billboard/Ad ☐ Other:_____

What are your chief complaints and/or reasons for seeking HRT? Please check all that apply:

☐ Acne	☐ Difficulty Concentrating	☐ Hair Thinning/Loss	☐ Low Energy	☐ Sore Muscles/Joints
☐ Bone Density Loss	☐ Dull/Dry Skin	☐ Heat/Cold Intolerance	☐ Low Mood	☐ Testicular Shrinkage
☐ Brain Fog	☐ Dry Hair/Brittle Nails	☐ Headache/Migraine	☐ Memory Issues	☐ Urogenital Atrophy
☐ Constipation	☐ Erectile Dysfunction	☐ Hot Flashes	☐ Mood Swings	☐ Vaginal Dryness
☐ Decreased Libido	☐ Fat Deposits	☐ Increased Stress	☐ Muscle Loss	☐ Water Retention
☐ Depression	☐ Fatigue	☐ Increased Wrinkles	☐ Night Sweats	☐ Weight Gain
☐ Difficulty Sleeping	☐ Fibromyalgia	☐ Joint Pain/Swelling	☐ Saggy/Loose Skin	☐ Weight Loss

Are there any other reasons you are seeking HRT not listed above? Please describe below:

_____

_____

Have you ever used Hormone Replacement Therapy (HRT) in the past? Check all that apply: ☐ Yes ☐ No

☐ Estrogen	☐ Human Growth Hormone	☐ Progesterone	☐ Testosterone
☐ Estrogen Blocker	☐ Oestrogen	☐ Progestin	☐ Tibolone

If you have ever used Hormone Replacement Therapy (HRT) in the past, please mark all forms you've tried:

☐ Buccal Tablet	☐ Injection (IM)	☐ Intravaginal Ring	☐ Oral Tablet
☐ Creams (Topical)	☐ Intravaginal Cream	☐ Intrauterine Device	☐ Patch (Topical)
☐ Gels (Topical)	☐ Intravaginal Tablet	☐ Nasal Gel	☐ Pellet (Implant)

List all previous HRT Dosages, Frequency, and Forms/Routes of Administrations

_____

_____

1- Do you have known allergies/sensitivities to:
☐ Adhesives ☐ Benzyl Alcohol ☐ Latex ☐ Lidocaine ☐ Topical Anesthetics

2- Have you ever had an allergic reaction to sutures/stitches? ☐ Yes ☐ No

3- Have you ever had an adverse reaction or significant side effects to HRT in the past? ☐ Yes ☐ No
If you marked an allergy above in line item 1 or marked yes to items 2-3 above, please explain below:

_____

_____

Do you have any surgical implants, screws, pins in treatment area(s)? ☐ Yes ☐ No

Do you currently take/use any medications that may cause increased risk of bleeding or delayed healing?
☐ Yes ☐ No
If yes, please check all that apply: ☐ Anti-Platelets ☐ Blood Thinners ☐ Corticosteroids ☐ NSAIDS

Female Medical History:

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Menopausal

Birth Control: ☐ Abstinence ☐ Birth Control Pill ☐ Depo Provera ☐ Hysterectomy ☐ IUD ☐ Menopause ☐ Nexplanon ☐ NuvaRing ☐ Tubal Ligation ☐ Vasectomy

☐ Other (Please Explain): _____

Date of Last Menses: _____ **Pregnancies:** _____ **Live Births:** _____

Pap Results/Date: _____ **Mammogram Results/Date:** _____

Are you experiencing or have you ever been diagnosed with any of the following:

☐ Blood Clots ☐ Breast Cancer (Family) ☐ Endometrial Cancer ☐ Vaginal Bleeding (Abnormal)
☐ Breast Cancer (Self) ☐ Ductal Hyperplasia (Breast) ☐ Uterine Fibroids

Male Medical History:

Do you currently have or had within past 12 months:

☐ Bladder Infection ☐ Enlarged Prostate ☐ Prostate Infection ☐ Testicle Cancer (Ever Had)
☐ Blood In Urine ☐ Kidney Infection ☐ Prostate Cancer (Ever Had)

Prostate Exam Date/Results: _____ **PSA Results/Date:** _____

Vasectomy? ☐ Yes ☐ No **Trying To Conceive?** ☐ Yes ☐ No

General Medical History:

Date of last blood work: _____ **Date of last colorguard or colonoscopy:** _____

Describe any abnormal results: _____

_____

Have you ever been diagnosed with or currently have:

☐ Angina/Chest Pain ☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Neurological Disorder
☐ Arthritis/Rheumatism ☐ Diabetes ☐ High Cholesterol ☐ Orthopedic Disorder
☐ Asthma ☐ Emotional Disorder ☐ Immune Deficiency ☐ Poor Wound Healing
☐ Autoimmune Disorder ☐ Gallbladder Disease ☐ Kidney Disease ☐ Renal Insufficiency
☐ Blood Clotting Disorder ☐ Genitourinary Disorder ☐ Kidney Stones ☐ Stroke/TIAs
☐ Cancer ☐ Heart Attack ☐ Liver Disease ☐ Thyroid Issues
☐ Chemical Dependence ☐ Heart Disease ☐ Muscle Disorder

Please explain any items you marked above:

_____

_____

Do you have any other medical issues not listed above? ☐ Yes ☐ No

If yes, please describe issue here: _____

Do you consume alcohol? ☐ Yes ☐ No

If yes, please list number of drinks you consume per week: _____

Do you smoke? ☐ Yes ☐ No

If yes, please describe how often and how much you smoke: _____

If there is anything else you'd like the Nurse or Physician to know, please let us know here:

_____

_____

Patient Name: _____ **DOB:** _____ **Date:** _____

Medication Record

Please list all medications, over the counter drugs, and herbal supplements you are currently taking. Please include any prescription topical creams and hormone replacement therapy medications/implants.

Medication or Supplement	*Frequency*	*Dose*	*Purpose/Prescribed For*

Allergies & Sensitivities

Do you have any allergies or sensitivities to foods, medications, implants, etc? ☐ Yes ☐ No

If yes, please list all allergens and how you react to them:

_____

_____

Surgical History

Have you been hospitalized or received acute medical care, including surgeries, in the past year? ☐ Yes ☐ No

If yes, please describe here: _____

Primary Care Physician: _____ **Phone:** _____

List all surgical procedures you have had with approximate dates:

_____

_____

*I affirm the information I have provided regarding my health history, medication record, and prior surgeries and aesthetic treatments is accurate to the best of my knowledge. I acknolwedge that **YOUR BUSINESS NAME** Staff are not responsible for any errors that may occur as a result of any omissions or incorrect information on this form.*

Patient Name (Print) _____ **Patient Signature** _____ **Date** _____