Optimal Health Montana
Missoula, MT

406.223.0721
optimalhealthmt@gmail.com
www.ohm406.com

Disclosure: OHM always keeps your information private. However, we do not have encryption ability for your questionnaire. Please only fill in what you are comfortable with, knowing that we NEVER share your information!

HORMONE REPLACEMENT INTAKE FORM

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

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

Phone:_____ Email:_____

Occupation or previous occupation, if retired:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

What are your goals for this consultation and BHRT? *If you aren't sure, that's ok!*

_____

How did you hear about me?

☐ Social Media:_____ ☐ Referral:_____

☐ Internet Search ☐ Other:_____

PLEASE RATE YOUR CURRENT SYMPTOMS:

1 - Mild 2 - Moderate 3 - Severate **If no symptoms, leave box blank**

Estrogens:

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Depression
- ☐ Brain Fog
- ☐ Fatigue/ Low Energy
- ☐ Weight Gain
- ☐ Decreased Sensuality
- ☐ Pain During Intercouse
- ☐ Urinary Leakage
- ☐ Droopy Breasts
- ☐ Dry,Dehydrated Skin
- ☐ Vaginal Dryness
- ☐ Thinning Skin
- ☐ Loss of Glow
- ☐ Dry Eyes*
- ☐ Vertical Lines Around Mouth
- ☐ High Cholesterol
- ☐ Vaginal Itching
- ☐ Back and Join Paint
- ☐ Low Bone Density*
- ☐ UTI
- ☐ Heart Palpitations

Signs of Excess
- ☐ Breast Tenderness
- ☐ Breast Fullness
- ☐ Nipple Tenderness
- ☐ Fluid Retention

Progesterone:

- ☐ Difficulty falling & staying asleep
- ☐ Irritability
- ☐ Anxious
- ☐ Mood Swings
- ☐ Unable to Relax
- ☐ Hot Flashes
- ☐ Swollen, Painful Breasts
- ☐ Breast Lumps/Fibrocystic Breasts
- ☐ Swollen Feet and Ankles
- ☐ Period Irregularities
- ☐ Scanty Menstruation
- ☐ Heavy Bleeding
- ☐ PMS
- ☐ Fibroids/ Endometriosis
- ☐ History of Infertility
- ☐ History of Miscarriage
- ☐ Headaches
- ☐ Acne
- ☐ Swollen Face
- ☐ Low Bone Density
- ☐ Drowsiness

Signs of Excess

Testosterone/ DHEA:

- ☐ Loss of Muscle
- ☐ Abdominal Weight Gain
- ☐ Cellulite
- ☐ Varicose Veins
- ☐ Loss of Libido
- ☐ Lack of Orgasm
- ☐ Low Clitoral Sensitivity
- ☐ Dry Eyes
- ☐ Loss of Confidence
- ☐ Low Energy/Stamina
- ☐ Digestive Issues
- ☐ Poor Tissue Repair
- ☐ Immune Dysfunction
- ☐ Low Bone Density*
- ☐ Joint Pain

Signs of Excess

- ☐ Unwanted Hair Growth
- ☐ Voice Changes
- ☐ Aggression
- ☐ Oiliness of Skin
- ☐ Hair Loss on Head
- ☐ Acne*

*Multiple Reasons for this Symptom

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

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

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

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

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

_____

_____

Have you ever had an adverse reaction or significant side effects to HRT in the past? ☐ Yes ☐ No

Please explain below:

_____

_____

Do you have known allergies/sensitivities to:

☐ Adhesives ☐ Benzyl Alcohol ☐ Latex ☐ Lidocaine ☐ Topical Anesthetics ☐ Sutures/Stitches

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 ☐ High dose NSAIDS

Female Medical History:

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Peri-menopausal

Current Birth Control:

- ☐ Abstinence
- ☐ Birth Control Pill
- ☐ Depo Provera
- ☐ Hysterectomy
- ☐ Mirena/Copper
- ☐ 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 (Self)
- ☐ Breast Cancer (Family)
- ☐ Ductal Hyperplasia (Breast)
- ☐ Endometrial Cancer
- ☐ Uterine Fibroids
- ☐ Vaginal Bleeding (Abnormal)

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

Please explain any items you marked above:

_____

_____

Digestion / Elimination: Have you recently experienced any of these symptoms?

- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ IBS
- ☐ Other (Please Explain):_____

Do you have a Daily Bowel Movement? ☐ Yes ☐ No

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:

_____

Do you consume caffeine? Coffee and/or supplements ☐ Yes ☐ No

If yes, please list the number of cups and the amount of supplements (in mg) you consume each day:

_____

Is there anything else you'd like to share with me?

_____

_____

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

Medication Record

Please list any medications, over-the-counter drugs, and vitamins or supplements you currently take. Please also 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 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 acknowledge that Optimal Health Montana staff is not responsible for any errors that may occur as a result of any omissions or incorrect information on this form. I acknowledge that OHM, Missy Miculka, is not a doctor, nor is she offering medical advice, I am responsible for my choices.

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