INTAKE FORM

Regenerative MedSpa of Buckhead

FEMALE

Bioidentical Hormone Replacement Therapy Program

Thank you for your interest in BHRT. In order to determine if you are a candidate for bioidentical hormone pellets, we need laboratory and health history forms. The information below is valuable for our assessment of your health. Please fill it out to the best of your ability. **We look forward to partnering with you to restore your youthfulness and improve your health!**

Patient Questionnaire

Today's Date:_____

Last Name: _____ First Name: _____ Middle Name:_____

Birth Date: _____ Age:_____ Occupation: _____

Home Address: _____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____ May we contact you via email? ( )Yes ( ) No

In case of Emergency Contact:_____ Cell Phone:_____

Relationship:_____

Primary Care Physician's Name:_____ Phone:_____

PCP Address:_____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widowed ( ) Living with Partner ( ) Single

In the event we cannot contact you by the means you've provided above, we would like to know if we have permission to speak to your spouse or significant other about your treatment. By giving the information below, you are giving us permission to speak with your spouse or significant other about your treatment.

Spouse/Partner's Name:_____ Phone:_____

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Medical History

Any Known Drug Allergies:_____

Medications Currently Taking:_____

Current Hormone Replacement Therapy:_____

Past Hormone Replacement Therapy: _____

Nutritional / Vitamin Supplements:_____

Surgeries? List All and When:_____

Last Menstrual Period (Estimate Year if Unknown):_____

Preventative Medical Care:
( ) Medical/GYN exam in the last year
( ) Mammogram in the last 12 months
( ) Bone Density in the last 12 months
( ) Pelvic ultrasound in the last 12 months

High Risk Past/Medical Surgery History:
( ) Breast Cancer
( ) Uterine Cancer
( ) Ovarian Cancer
( ) Hysterectomy with removal of ovaries
( ) Hysterectomy only
( ) Oophorectomy

Birth Control Method:
( ) Menopause
( ) Hysterectomy
( ) Tubal Ligation
( ) Birth Control Pills
( ) Other

Social:
( ) I am sexually active
( ) I want to be sexually active
( ) I have completed my family
( ) My sex has suffered
( ) I haven't been able to have an orgasm

Medical Illnesses:
( ) High blood pressure
( ) High cholesterol
( ) Hypertension
( ) Heart disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary embolism
( ) Arrythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other autoimmune disease
( ) Fibromyalgia
( ) Trouble passing urine
( ) Chronic liver disease (fatty liver, cirrhosis)
( ) Diabetes
( ) Thyroid disease
( ) Arthritis
( ) Depression / Anxiety
( ) Cancer type:_____
year:_____

Habits:
( ) I smoke cigarettes or cigars _____ per day
( ) I drink alcoholic beverages _____ per week
( ) I drink more than 10 alcoholic beverages / week
( ) I use caffeine _____ per day

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Estrogen Deficiency Symptoms	Yes	No
Are you experiencing hot flashes?		
Do you feel exhausted on a daily basis?		
Do you suffer from headaches/migraines?		
Do you suffer from night sweats?		
Are you experiencing vaginal dryness?		
Have you noticed mild losses of bladder control?		
Are you noticing bouts of mild to severe depression?		
Have you had a history of urinary tract infections?		
Has there been an increase in forgetfulness?		
Are you having trouble concentrating?		
Have you noticed a decrease in your ability to explain things?		
Do you suffer from occasional bouts of rapid heartbeat?		
Are you moodier?		
Do you cry easily?		

Progesterone Deficiency Symptoms	Yes	No
Are you noticing lumpiness in your breasts?		
Are you experiencing anxiety?		
Do you have a problem with bloating?		
Do you become easily stressed?		
Are you becoming moodier with age?		
Are you experiencing breakthrough bleeding?		
Do you suffer from menstrual cramps or PMS?		
Do you suffer from low body temperature?		
Do you currently have or have a family history of endometriosis?		
Do you suffer from sleep disorders?		
Do you have heavy periods?		
Do you snore?		
Are you experiencing pain in multiple areas of your body?		
Have you had an increase in weight?		

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Testosterone Deficiency Symptoms	Yes	No
Has your sex drive decreased?		
Have you noticed increased belly fat?		
Have you noticed an increase in the size of your breasts?		
Are you developing cellulite?		
Have you had a decrease in self-esteem?		
Do you feel like flopping onto the couch after work?		
Are your eyelids drooping?		
Have you noticed that your hair is thinning?		
Do you feel hypersensitive?		
Are you gaining weight?		
Are your muscles turning to flab?		
Do you have high triglycerides, high LDL, and low HDL?		

Additional Symptoms or Concerns you'd like your provider to know:

We value your business and ask that you respect our business scheduling policies. Please notify us at least 24 hours in advance of any cancellation. All cancellations with less than 24-hour notice and no-show appointments are subject to a $75 cancellation fee.

Print Name Signature Date

_____ (Initial) I understand as a participant in this Regenerative MedSpa BHRT program, I will discuss medical information in the presence of people, staff, and the clinician If I have medical concerns that are of a very private nature, I will request to discuss with the clinician in a private setting or will schedule an individual office visit. Additionally, I have been notified of my rights to privacy.