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Dr. William Meadows, Medical Director

## **Female Hormone Replacement Therapy Packet**



### Patient Demographics

LAST NAME:		FIRST NAME:		M.I.
D.O.B.		GENDER:		MARITAL STATUS:
SOCIAL SECURITY NO.:			PREFERRED LANGUAGE:	
RACE:				ETHNICITY:
HOME ADDRESS:				
CITY:		STATE:		ZIP:
PHONE #1:			PHONE #2:	
EMAIL:				
EMPLOYER:			WORK PH:	
ALLERGIES (Medical Alert):				
PRIMARY CARE PHYSICIAN:			PHONE:	
REFERRING PHYSICIAN:			PHONE:	
PHARMACY NAME:			PHONE:	
ADDRESS:				
CITY:		STATE:		ZIP:
IN CASE OF EMERGENCY CONTACT:				
FIRST NAME:			LAST NAME:	
RELATION			PHONE	
INSURANCE INFORMATION - PRIMARY				
Insured Name:		Relationship to Patient:		DOB:
Insurance Company:			PHONE:	
Insurance Company Address:				
CITY:		STATE:		ZIP:
Policy No.		Group No.		Employer:
INSURANCE INFORMATION - SECONDARY				
Insured Name:		Relationship to Patient:		DOB:
Insurance Company:			PHONE:	





### Allergies

List all allergies and reactions. (including medications, substances, seasonal, etc.)

#### ALLERGY

#### REACTION


### Family History

List all illnesses (heart disease, stroke, diabetes, hypertension, cancer – type, etc.)

If a family member is deceased, please list age of death and cause, if known.

Relationship	Age	Medical Problem(s)/Cause of Death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		



### Social History

Please remember, this information is strictly confidential.  
It will be used **only** to address your symptoms and/or complaints.

Do you smoke cigarettes?  Currently  Past History  Never  
If yes, how many per day? \_\_\_\_\_ How long have you smoked, total? \_\_\_\_\_

Do you drink alcohol?  Currently  Past History  Never  
If yes, how of each type do you have in an average week?  
Beer: \_\_\_\_\_ per week Wine: \_\_\_\_\_ per week Spirits: \_\_\_\_\_ per week  
How long have you been drinking, in total? \_\_\_\_\_

Do you use illicit drugs (marijuana, cocaine, amphetamines, non-prescribed opiates or narcotics, LSD/acid, etc.)?  
 Currently  Past History  Never  
If currently or in the past, list the substances used, and how often they are/were used.

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### Gynecological History

Last PAP smear: Date: \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Ph#: \_\_\_\_\_  
Have you ever had an abnormal PAP?  YES  NO  
If yes, what was the abnormality and what follow-up did you have? \_\_\_\_\_

Last Mammogram: Date: \_\_\_\_\_  
Physician/Facility Name: \_\_\_\_\_ Ph#: \_\_\_\_\_  
Have you ever had an abnormal mammogram?  YES  NO  
If yes, what was the abnormality and what follow-up did you have? \_\_\_\_\_

Have you ever had a breast biopsy?  YES, Date: \_\_\_\_\_  NO  
If yes, what was the result, and what follow-up did you have, if any? \_\_\_\_\_

Have you ever had a cervical biopsy?  YES, Date: \_\_\_\_\_  NO  
If yes, what was the result, and what follow-up did you have, if any? \_\_\_\_\_



Have you noticed breast skin or nipple changes? \_\_\_\_\_ YES \_\_\_\_\_ NO

Have you noticed any lumps in your breasts? \_\_\_\_\_ YES \_\_\_\_\_ NO

Are you using a birth control method? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, what kind? \_\_\_\_\_

Are you still having menstrual periods? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, when was the first day of your last period? \_\_\_\_\_

Please describe any problems you have with your periods: \_\_\_\_\_

Periods are: Regular irregular painful crampyheavy light other

Age periods began: \_\_\_\_\_ # days of bleeding: \_\_\_\_\_ cycle length (days): \_\_\_\_\_

If you are no longer having periods, at what age did your periods stop? \_\_\_\_\_

If your periods stopped less than one year ago, how many months ago was your last period? \_\_\_\_\_

Did your periods stop because you had a hysterectomy? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, what was the reason for the surgery? \_\_\_\_\_

Were the ovaries removed at the same time? \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ UNSURE

Do you have a history of any of the following cancers? Circle those which apply to you. \_\_\_\_\_ NONE APPLY

Breast Cervix Colon Fallopian Tube Ovary Uterus Vagina Vulva

Other \_\_\_\_\_

### Hormone Therapy History

Have you been treated with any hormone replacement therapy? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, give type, reason, and periods of treatment.

HORMONE	DOSE	REASON	START DATE	STOP DATE



Ocala, FL ~ Tampa, FL




## Estrogens

Check which of these symptoms are troublesome and have persisted over time.

Estrogen Deficiency	Estrogen Excess/Progesterone Deficiency	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Bone Loss</li> <li><input type="checkbox"/> Depressed</li> <li><input type="checkbox"/> Foggy Thinking</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Heart Palpitations/Arrhythmia</li> <li><input type="checkbox"/> Hot Flashes</li> <li><input type="checkbox"/> Memory Lapses</li> <li><input type="checkbox"/> Night Sweats</li> <li><input type="checkbox"/> Sleep Disturbances</li> <li><input type="checkbox"/> Tearful</li> <li><input type="checkbox"/> Urinary Incontinence</li> <li><input type="checkbox"/> Vaginal Dryness</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Anxious</li> <li><input type="checkbox"/> Bleeding Changes</li> <li><input type="checkbox"/> Breast Cancer</li> <li><input type="checkbox"/> Cold Body Temperature</li> <li><input type="checkbox"/> Cystic Ovaries</li> <li><input type="checkbox"/> Elevated Triglycerides</li> <li><input type="checkbox"/> Fibrocystic Brest</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Heavy Menses</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Irritable</li> <li><input type="checkbox"/> Low Libido</li> <li><input type="checkbox"/> Mood Swings (PMS)</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Sugar Craving</li> <li><input type="checkbox"/> Tender Breasts</li> <li><input type="checkbox"/> Uterine Fibroids</li> <li><input type="checkbox"/> Water Retention</li> <li><input type="checkbox"/> Weight Gain – Hip Area</li> </ul>

## Androgens

Check which of these symptoms are troublesome and have persisted over time

Androgen Excess	Androgen Deficiency	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Acne</li> <li><input type="checkbox"/> Anxious</li> <li><input type="checkbox"/> Breast Cancer</li> <li><input type="checkbox"/> Elevated Triglycerides</li> <li><input type="checkbox"/> Increased Body Hair</li> <li><input type="checkbox"/> Increased Facial Hair</li> <li><input type="checkbox"/> Irritable</li> <li><input type="checkbox"/> Nervous</li> <li><input type="checkbox"/> Oily Skin</li> <li><input type="checkbox"/> Ovarian Cysts</li> <li><input type="checkbox"/> Prostate Problems</li> <li><input type="checkbox"/> Sleep Disturbances</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Aches/Pains</li> <li><input type="checkbox"/> Anxious</li> <li><input type="checkbox"/> Apathy/Decreased Passion for Life</li> <li><input type="checkbox"/> Bone Loss</li> <li><input type="checkbox"/> Decreased Muscle Mass</li> <li><input type="checkbox"/> Depressed</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Fibromyalgia</li> <li><input type="checkbox"/> Foggy Thinking</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Heart Palpitations/Arrhythmia</li> <li><input type="checkbox"/> Irritable</li> <li><input type="checkbox"/> Low Libido</li> <li><input type="checkbox"/> Memory Lapses</li> <li><input type="checkbox"/> Sleep Disturbances</li> <li><input type="checkbox"/> Thinning Skin</li> <li><input type="checkbox"/> Urinary Incontinence</li> <li><input type="checkbox"/> Vaginal Dryness</li> </ul>

## Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess	Cortisol Deficiency





<input type="checkbox"/> Acne	<input type="checkbox"/> Increased Facial Hair	<input type="checkbox"/> Aches/Pains
<input type="checkbox"/> Anxious	<input type="checkbox"/> Loss of Muscle Mass	<input type="checkbox"/> Allergies
<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Low Libido	<input type="checkbox"/> Apathy/Decreased Passion for Life
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Elevated Triglycerides	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Chemical Sensitivity
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Cold Body Temperature
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Stress	<input type="checkbox"/> Exhaustion/Fatigue
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sugar Cravings	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Heart Palpitation/Arrhythmia	<input type="checkbox"/> Thinning Skin	<input type="checkbox"/> Irritable
<input type="checkbox"/> Irritable	<input type="checkbox"/> Weight Gain – Waist	<input type="checkbox"/> Stress
<input type="checkbox"/> Increased Body Hair		<input type="checkbox"/> Sugar Craving

<b>Thyroid</b>		
Check which of these symptoms are troublesome and have persisted over time		
Thyroid Excess	Thyroid Deficiency	
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty Conceiving/Infertility <input type="checkbox"/> Heart Palpitations/Arrhythmia <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritable <input type="checkbox"/> Nervousness/Anxious/Panic Attacks <input type="checkbox"/> Tremors/Shakiness <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Aches/Pains <input type="checkbox"/> Coarse Dry Skin <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Constipation <input type="checkbox"/> Fatigued/Weakness <input type="checkbox"/> Hair Loss	<input type="checkbox"/> Inability to Lose Weight <input type="checkbox"/> Lack of Motivation <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Stress <input type="checkbox"/> Unexplained Weight Gain <input type="checkbox"/> Voice Has Become Hoarse

<b>System Review - Check the appropriate box for each question.</b>			
Constitutional/ID/Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever and chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			



<b>Respiratory</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Do you have a persistent cough?			
Do you have recurrent sinus infections?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema?			
<b>Cardiovascular</b>			
<b>Cardiovascular</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Do you have vascular disease or artery blockages/aneurysms?			
Have you ever been diagnosed with any heart condition?			
Have you ever been diagnosed with a blood clot?			
<b>Gastrointestinal</b>			
<b>Gastrointestinal</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Do you have problems swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			
<b>System Review Continued - Check the appropriate box for each question.</b>			
<b>Endocrine</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Do you urinate frequently or in larger amounts than usual?			
Do you have greater than normal urge to eat?			
Do you have elevated blood sugar? Diabetes			



Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
<b>Neurological</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
<b>Urologic/Renal</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</b>
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had kidney problems?			



### Past Medical History

List any medical problems or illnesses you have had or have.  
Include any hospitalizations and accidents with approximate dates.

Date	Medical Diagnosis, Illness, Accident, etc.

### Past Surgical History

List any surgeries, and the dates they were performed.

Date	Surgery Description

### Present Symptoms

Briefly describe your symptoms. What do you feel is the most important factor to your present symptoms?

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Physician Notes: \_\_\_\_\_

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**Disclosure/Liability Waiver**  
**Padgett Medical Center, LLC – Bio-Identical Hormone Replacement Program**

While numerous safety measures are taken by our physicians and staff, incidental events may occur that are beyond the control of our physicians or staff. Within the medical community, there are opposing views with respect to the use of bio-identical hormonal replacement therapies. The use of bio-identical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bio-identical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Padgett Medical Center, LLC, its staff, or treating providers for injury to you on account of involvement in the Bio-identical Hormone Replacement Program. You have carefully read this waiver and fully understand it is a release of liability.

I accept all terms and conditions of this program.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Birth