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FEMALE HORMONE REPLACEMENT CONSULTATION FORM

Name : _____ Date : _____

Date of birth : _____ Age : _____ ☐Male ☐Female ☐ Non-Binary

Address: _____

City: _____State : _____ Zip Code : _____

Phone:_____ Email : _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us?_____

Are you referred by someone? If so, whom?_____

Would you like to be added to our email list for news and exclusive offers? _____

MEDICAL HISTORY

Please mark any of the following conditions you may currently have

☐ High Blood Pressure
☐ Breastfeeding
☐ Bleeding Disorders
☐ Diabetes
☐ Frequent Headaches
☐ Thyroid
☐ Hepatitis
☐ Pregnancy
☐ Stroke
☐ Birth Control
☐ Seizures
☐ Cancer
☐ Lung Disease
☐ Illicit Drug User
☐ Heart Disease
☐ Other _____

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Any other conditions? _____

If you ticked any boxes, please give further details _____

_____

Do you have any allergies? □ Yes □ No

If so, please list all _____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones and topical

_____

_____

Are you currently pregnant or trying to get pregnant? □ Yes □ No

Do you smoke? □ Yes □ No

Do you consume alcohol? □ Yes □ No

Have you ever had any hormone replacement therapy in the past? □ Yes □ No

If so, when was your last treatment? _____

Any likes or dislikes about past treatments? _____

_____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my medical members and the employer for any injury or damages incurred due to any falsification of my medical history

_____ _____

Patient Name (Printed) **Patient Signature**

_____

Date

Consent for Hormone Replacement Therapy

I, _____, the undersigned, authorize and give my Informed Consent to An Optimal You for the administration of hormone replacement therapy.

Expected Benefits of Hormone Replacement Therapy:

- Expected benefits include control of symptoms associated with declining hormone levels.
- ***Possible benefits of this therapy may help prevent, reduce, or control physical diseases and dysfunction associated with declining hormone levels, through hormonal replacement. Increased libido, energy, and sense of well-being; increased muscle mass strength and stamina; decreased frequency and severity of migraine headaches; decrease in mood swings, anxiety, and irritability; decreased weight; decrease in risk or severity of diabetes; decreased risk of heart disease; decreased risk of Alzheimer's and dementia.***
- ***I have been fully informed, and I am satisfied with my understanding, that this treatment may be viewed by the medical community as new, controversial, and unnecessary by the Food and Drug Administration.***
- I understand that my healthcare provider cannot guarantee any health benefits or that there will be no harm from the use of hormone replacement therapy.

Risks and Side Effects of Hormone Replacement Therapy:

Some of the following risks/adverse reactions are derived from the official Food and Drug Administration "FDA" labeling requirements for these drugs, for therapeutic drug levels in the bloodstream. My healthcare provider may prescribe these medications at dosages designed to achieve physiologic levels of hormones in my bloodstream or urine generally associated with those of a 20-35-year-old person and would be within the "normal" or "average" blood concentrations of that age group.

• General

I understand that the general risks of this proposed therapy may include, but are not limited to, bruising, soreness or pain, and possible infection for hormones administered by injection.

• I understand that there are risks (both known and unknown) to any medical procedure, treatment, and therapy and that it is not possible to guarantee or give assurance of a successful result. I acknowledge and accept these known and unknown general risks.

- Such as Fluid retention, swelling of the hands and feet, uterine spotting, and facial breakout.

Testosterone:

• A prescription hormone, given by injection, pellet, transdermal cream, or patch. Risks of testosterone replacement include but are not limited to ***stimulation of benign and malignant prostate tumors.*** Testosterone replacement is contraindicated in patients with known prostate cancer. ***Side effects of testosterone replacement may include but are not limited to an increase in the red blood cells, determined by periodic measuring of your red blood.*** It is not a common occurrence and generally poses no health risk; it can be corrected by donating blood or with a therapeutic phlebotomy. ***Male pattern baldness, gynecomastia (breast enlargement), diminished sperm production, and a reduction in the size of the testicles may develop in men. Testosterone replacement may reduce insulin requirements in insulin-dependent diabetics. Older male patients may be at a slightly increased risk for the development of prostate enlargement when replacing testosterone.*** The concurrent use of testosterone with corticosteroids may enhance edema (fluid retention) formation. Edema may be a complication with testosterone replacement in patients with pre-existing cardiac, renal, or hepatic disease. It is not known whether testosterone replacement therapy will increase the risk of prostate cancer. ***The most common immediate side effects (occurring in approximately no more than 6% of users)*** include but are not limited to: acne. application site reaction, headache, hypertension (high blood pressure), abnormal liver function tests, and non-cancerous prostate disorder. Other side effects may include greasy hair and skin, a strong body odor, and aggressiveness.

Estrogen:

• A prescription hormone, given by injection, pellet, orally, or by transdermal cream or patch. Risks associated with estrogen replacement include, but are not limited to: heart attacks, blood clot formation, gallstones, increased risk of uterine cancer (if progesterone is not administered concurrently), and fibroid tumors. The Women's Health Initiative study demonstrated ***increased risk when estrogen replacement is initiated 10 or more years after menopause.*** Estrogen replacement is not recommended in women with a history of the following conditions: ***breast or uterine cancer, phlebitis and blood clots, gall bladder disease, uterine fibroma, and liver disease.*** Side effects may include, but are not limited to: ***increased body fat, fluid retention, uterine bleeding, depression, headaches, impaired glucose tolerance, and aggravation of migraines.***

Alternative to Hormone Replacement Therapy:

I understand the reasonable alternatives to hormone replacement therapy, which include:

• Leaving the hormone levels as they are and doing nothing. Risks may include but are not limited to experiencing symptoms of hormone deficiency, and increased risk for aging-related diseases or dysfunction resulting from declining hormone levels. This alternative may result in the need to treat diseases or dysfunctions associated with declining hormone levels as they appear clinically.

• Treating the symptoms of declining hormone levels as they develop with non-hormonal therapies. Risks may include but are not limited to increased risk for aging-related diseases resulting from declining hormone levels.

My Compliance Obligation While Receiving Hormone Replacement Therapy:

• I agree to comply with the proposed treatment and therapy as prescribed, including but not limited to the fact that I may be responsible for injecting, taking by mouth, applying to my skin, or administrating the hormone(s) that may be prescribed to me, and consent to periodic monitoring when requested, which may include:

o ***Laboratory monitoring of blood or urine chemistries and hormone levels***

o ***Physical examinations***

o ***Regular screening evaluations***

• ***I agree to notify you regarding all signs or symptoms of possible reactions to my therapy.***

• ***I agree to comply with all other healthy lifestyle activities that have been individually recommended for me.*** I have completely disclosed my medical history, including prescription and non-prescription medications that I am currently taking or plan to take during my treatment, as well as any other over-the-counter medications, recreational drugs or social substances, herbs, extracts, and other dietary supplements to you. I agree to comply with the recommendations regarding the continuation of these preparations.

• In the future I will receive recommendations in advance from you before stopping any prescribed therapeutic regimens or taking additional preparations that are not recommended by you.

• I certify that I am under the care of a physician(s) for any and all other medical conditions

Research and Economic Interests

• I understand that the prescribing practitioner is not engaged in any personal research and has no economic interests unrelated to my immediate care or treatment that may affect the physician's choice of treatment or medical judgment.

I certify that I have been given the opportunity to ask any and all questions I have concerning the proposed treatment, and I received all requested information, and all questions were answered. I fully understand that I have the right to not consent to hormone replacement therapy. I believe I have adequate knowledge upon which to base informed consent. I do now attest to reading and fully understanding this form and the contents and clinical meanings of such and discussing these procedures with my healthcare provider and consent to this treatment and hereby affix my signature to this authorization for this proposed long-term treatment. I have been given a copy of this consent form, and I understand fully all of the possibly represented implications and meanings of its writing and expectations.

Patient's Name: _____ Date: _____

(Please Print Name)

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____

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ALL PATIENTS: OBLIGATIONS & REPRESENTATIONS

Any questions I have regarding this treatment have been answered to my satisfaction. I will comply with the recommended dose and methods of administration. I also agree to participate in the initial and subsequent blood testing as required to monitor my hormone levels.

I have disclosed accurate and true information regarding my medical history, medications, and surgeries.

I certify that I am under the regular care of another physician for all other medical conditions. I will consult my primary care physician(s) for any other medical services I may require. I understand that this is a specialized practice. I also understand that I will continue under the care of my other physician(s) for any ongoing medical condition as well as for any medical consultation that I may need.

I assume full liability for any adverse effects that may result from the non-negligent administration of the proposed treatment. I waive any claim in law or equity for redress of any grievance that I may have concerning or resulting from the therapy, except as that claim pertains to negligent administration of the therapy.

I fully understand the nature and purpose of portions of the aforementioned treatment may be considered experimental because of the lack of adequate scientific evidence or peer-reviewed publications supporting the underlying premise of bio-identical hormone replacement therapy and that such therapy might even be considered by some medical professionals to be medically unnecessary because it is not aimed at treating a particular disease.

I understand that I may suspend or terminate treatment at any time and hereby agree to immediately notify the physician of any such suspension or termination.

I also understand there are possible benefits associated with this therapy but no guarantee has been made to me regarding the outcomes of this treatment. I also understand that the benefits derived from antioxidant therapy, hormone therapy, and drugs that alter hormone levels will cease or reverse if the therapy is discontinued.

ALL PATIENTS: CONSENT

I hereby authorize my physician to evaluate and treat the conditions I specified above. I understand that my physician may be assisted by other health professionals, as necessary, and agree to their participation in my care as it relates to the evaluation and treatment of the conditions this Consent to Treat covers. I am competent to sign this Consent to Treat and have done so of my own free will.

_____ _____

Printed Name Signature

_____

Date

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Name _____ Date _____

Symptoms

Sleep	N/A	Mild	Moderate	Severe
Anxiety	N/A	Mild	Moderate	Severe
Sex Drive	N/A	Mild	Moderate	Severe
Energy	N/A	Mild	Moderate	Severe
Digestion (Gas/Bloating)	N/A	Mild	Moderate	Severe
Inflammation/Pain	N/A	Mild	Moderate	Severe
Constipation	N/A	Mild	Moderate	Severe
Vaginal Dryness	N/A	Mild	Moderate	Severe
Hot Flashes	N/A	Mild	Moderate	Severe
Foggy Thinking	N/A	Mild	Moderate	Severe
Mood Swings	N/A	Mild	Moderate	Severe
Weight Gain	N/A	Mild	Moderate	Severe
Overeating	N/A	Mild	Moderate	Severe
Hair Loss	N/A	Mild	Moderate	Severe
Retained Fluid	N/A	Mild	Moderate	Severe
Headaches	N/A	Mild	Moderate	Severe
Slump in Energy in PM	N/A	Mild	Moderate	Severe
Frequent Infections/Sickness	N/A	Mild	Moderate	Severe

For Office Use:

Height:	Weight:	BP:

HORMONE REPLACEMENT

CANCELATION POLICY

To ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a $100 deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 72 hours before your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 72 hours notice, a $100 cancellation fee will be charged.

Please note that if you arrive more than 20 minutes late for your appointment, it will be considered a no-show, and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Patient Name (Printed)	Patient (signature)	Date