GENERATIONS
OB+GYN

PROVIDING EXCELLENCE IN WOMEN'S HEALTHCARE

RE: **HORMONE CONSULTATION**

Dear Patient,

You have scheduled an appointment for a Hormone Consultation with Cheryl L. Thomson, PA-C or Jennifer M. Annetta, WHNP-C.

Enclosed you will find all the necessary information and two important forms:
The Confidential Medical History Form and The Hormone Replacement Therapy Patient Information Form. It is a must that you bring both forms completely filled out to your appointment.

To test your hormones your provider will order a blood test. It is your responsibility to inquire with your insurance company if this is covered under your plan prior to being seen.

CANCELLATION POLICY: Appointments not cancelled within a 24-hour notice will result in a $50 patient charge. Thank you for your understanding.

Thank you,

Generations OB-GYN

Rev 9/25

39533 Woodward Ave ▪ Ste 140 ▪ Bloomfield Hills MI 48304 ▪ Ph (248) 647-9860 ▪ Fx (248) 647-9864 ▪ www.generationsobgyn.com

CONFIDENTIAL MEDICAL HISTORY FORM

Please complete all sections of this form to insure the Provider can review with you and design the best plan of care.

Today's Date _____

Name _____ Birth date _____ Age _____

Address _____ City _____ State _____ Zip _____

Phone _____ e-mail _____

Height _____ Weight _____

Doctor's Name _____ Address _____ Phone_____

Please answer these general health questions. Leave the Provider/Nurse column blank.

BHRT Questionnaire

GOALS	What was the motivation behind considering Bio-Identical Hormone Replacement Therapy? ☐ Physician ☐ Self ☐ Family member/friend ☐ Other _____ What are your goals with taking BHRT? _____ _____	PROVIDER/NURSE
SOCIAL	Please check any that apply: Do you use tobacco? ☐ NO ☐ YES, If yes, how often and how much _____ Do you use alcohol? ☐ NO ☐ YES, If yes, how often and how much _____	PROVIDER/NURSE
PRESCRIPTIVE MEDICATIONS	Please list any current prescriptive medications: Medication name / Strength / Date started / How often _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Hormones taken / Date started / Date stopped / Reason _____ _____ _____ _____ _____ _____ _____ _____	PROVIDER/NURSE
NUTRITIONAL/NATURAL SUPPLEMENTS	Please list any current products: Vitamins / Strength / Date started / How often _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Supplements _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Enzymes/Oils _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Recreational _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	PROVIDER/NURSE

OVER~THE~COUNTER

PROVIDER/NURSE

Please check all the products that you use both regularly and occasionally:

- ☐ Antihistine product (ex: Chloe-Trimeton®)
- ☐ Aspirin
- ☐ Combination product, cough & cold reliever (ex: Triaminic®)
- ☐ Cough Suppresant (ex: Robitussin DM®)
- ☐ Decongestant product (ex: Sudafed®)
- ☐ Diet aids/weight loss products (ex: Dexatrim®)
- ☐ Pain reliever
- ☐ Sleep aids (ex: Excefrin PM®, Unisom®, Sominex®)
- ☐ Other (please list) _____

MEDICAL CONDITIONS/DISEASES

PROVIDER/NURSE

Please answer any that apply to you:

Since the start of your first period, have you ever experienced an abnormal cycle?
☐ NO ☐ YES, if yes explain? _____

When was your last period? _____ How long did it last? _____

Do you have or have you ever had Premenstrual syndrome (PMS)? ☐ NO ☐ YES
If yes, describe your symptoms _____

Have you had a hysterectomy? ☐ NO ☐ YES, if yes date of surgery _____
Ovaries removed? ☐ NO ☐ YES

Have you had a tubal ligation (tubes tied) ☐ NO ☐ YES,
if yes, date of surgery _____

What was the date of your last mammogram? _____

What was the date of your last PAP smear? _____
Have you had a bone density scan? If so, when? _____

Please check all that apply to you:

- ☐ Arthritis or joint problems
- ☐ Blood clotting problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eye disease
- ☐ Headaches/migraines
- ☐ Hormonal related issues
- ☐ Heart disease (congestive heart failure)
- ☐ Emotional disorders (depression, anxiety)
- ☐ High cholesterol or lipids (hyperlipidemia)
- ☐ High blood pressure (hypertension
- ☐ Lung condition (asthma, COPD)
- ☐ Thyroid disease (type)_____
- ☐ Ulcers (stomach, esophagus)
- ☐ Other (please list) _____

DO YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING?

- ☐ Uterine cancer family member (s) _____
- ☐ Ovarian cancer family member (s) _____
- ☐ Breast cancer family member (s) _____
- ☐ Fibrocystic breast family member (s) _____
- ☐ Heart disease family member (s) _____
- ☐ Osteoporosis family member (s) _____

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BIO-IDENTICAL HORMONE REPLACEMENT THERAPY
PATIENT INFORMATION FORM

Patient Name _____ Today's Date _____

	ABSENT	MILD	MODERATE	SEVERE
Weight Gain	☐	☐	☐	☐
Heavy/Irregular Menses	☐	☐	☐	☐
Hot Flashes	☐	☐	☐	☐
Dry Skin/Hair	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Night Sweats	☐	☐	☐	☐
Vaginal Dryness	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Irritability	☐	☐	☐	☐
Mood Swings	☐	☐	☐	☐
Breast Tenderness	☐	☐	☐	☐
Sleep Disturbances/Insomnia	☐	☐	☐	☐
Cramps	☐	☐	☐	☐
Breakthrough Bleeding	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Memory Loss	☐	☐	☐	☐
Bladder Symptoms	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Harder to Reach Climax	☐	☐	☐	☐
Sex Drive Decreased	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐

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