



General Information

Date: _____

Name: _____ **Age:** ____ **Birth date:** _____

Street Address: _____ **Apt.** _____

City: _____ **State:** _____ **Zip:** _____

Occupation: _____

Telephone number: Cell _____ **Home** _____

Status: Married Single Divorced Widowed **Religion:** _____

How did you hear about us? _____

If you had a referral, who referred you? _____

Have you discussed HRT with your Physician? _____

Do you understand what Natural Hormone Replacement is? _____

What are your three main symptoms/concerns?:

1. _____ **Since When?** _____

2. _____ **Since When?** _____

3. _____ **Since When?** _____



MEDICAL STATUS

Primary Care Physician: _____ **Phone:** _____

Address: _____ **Fax:** _____

Other Physicians Currently Seeing: _____

General Health: Excellent Good Fair Poor

Height: _____ **Weight** _____

Allergies: _____ **Blood Type:** _____

Current Diagnosis or Medical Conditions: _____

Current Medications: _____

Current Vitamins or OTC products: _____

Current Herbs/etc: _____

Are you currently on Natural Progesterone Cream? Yes No If Yes, brand name: _____

How long have you been on Progesterone Cream? _____

How much are you using and when? _____

Current Hormone Replacement Therapy:

Name: _____ **Strength:** _____ **Date Started:** _____

How and when do you take current HRT?: _____

Previous Hormone Replacement Therapy: Name: _____

Strength _____

Reason for Change: _____



Any lab results you may wish to enclose would be helpful for your evaluation

Lab	Date	Serum	Saliva	Results
FSH				
Progesterone				
Estriol (E3)				
Estradiol (E2)				
Estrone (E1)				
Testosterone				
Total				
Free				
DHEA Sulfate				
Cholesterol				
Triglycerides				
Total				
HDL				
LDL				

Bone Density: Yes No Date:_____ Type: Back Hip T:Score_____

Have you ever had a mammogram?: Yes No Date:_____ Results:

Have you ever had your Thyroid tested? Yes No Date:_____ TSH:_____
T4:_____ Free T3:_____ Other:_____



Current and Past Medical Conditions

Please check the ones that apply to you:

	Y	N	Date of Diagnosis		Y	N	Date of Diagnosis
Heart Disease				High Blood Pressure			
Stroke				Varicose Veins			
Clotting Defects				Diabetes			
Kidney Trouble				Epilepsy			
Fractures				Arthritis			
Colitis				Gall bladder Disease			
Irritable Bowel				Asthma			
Ulcers				Autoimmune disorder			
Fibroymalgia				Osteoporosis			
Chronic Fatigue				Cancer			
Eating Disorder							

HABITS

Dietary Restrictions: _____

Meal Choices: Breakfast: _____

Lunch: _____

Dinner: _____

Do you get routine exercise? _____ **What type?:** _____ **How often?** _____

Do you use tobacco products? Yes No How Much?: _____ **How Long?:** _____

Do you use alcohol products?: Yes No How Much?: _____ **How Long?:** _____

Do you use caffeine products: Yes No How Much?: _____ **How Long?:** _____



FAMILY HISTORY

RELATIVE	IMPORTANT DISEASES	LIVING	DECEASED
Mother			
Father			
Brothers			
Sisters			
Aunts			
Uncles			
Paternal Grandmother			
Maternal Grandmother			
Maternal Grandfather			

GYNECOLOGICAL HISTORY

Age at first period: _____ Date of last period: _____

Date of last pelvic exam: _____ and Pap smear: _____ Results: _____

Have you ever had an abnormal Pap?: Yes No When? _____

How many times? _____

Treatment: _____

Are you sexually active?: Yes No Are you trying to get pregnant?: Yes No

Current birth control method: _____ How Long? _____

Problem with it: _____ How Long? _____

Past birth control and related problems: _____



Have you ever been on birth control?: Yes No Brand: _____
How Long? _____ Side Effects?: _____

PLEASE FILL OUT NEXT SECTION EVEN IF NOT CYCLING NOW

How many days from start of one period to the start of next: _____

Number of days of flow: _____ Amount of bleeding: _____

Amount of cramping: _____

Premenstrual Symptoms: _____

Starting and ending when?: _____

Any current changes in your normal cycle?: _____

PLEASE FILL OUT THIS SECTION EVEN IF NOT CYCLING NOW

Any bleeding between periods?: _____ When?: _____

Any pelvic pain, pressure or fullness?: _____ Describe: _____

Any unusual vaginal discharge or itching?: _____ Describe: _____

Treatment: _____

Age at first pregnancy: _____ How many full term pregnancies?: _____

Problems: _____

Any interrupted pregnancies? Miscarriages?: Yes No Abortions? Yes No

Which pregnancy?: _____ How far along?: _____



Have you had a tubal ligation?: Yes No When?:_____ Cycle or symptoms change after?:_____

Have you had a hysterectomy?: Yes No When?:_____ Why?:_____

Symptoms change after hysterectomy?_____

Have you had any part or whole ovary removed?: Yes No When?:_____ Why?:_____

Symptoms change after?:_____

Age other in menopause?:_____

Name of Gynecologist: _____

Telephone:_____

Fax: _____

Name of Primary Care Physician:_____

Telephone: _____

Fax: _____



SYMPTOMS LIST

The following score sheet will help determine if hormone testing is needed and which tests to order. Each category is divided into hormone deficiency and excess, as each has a different subset of symptoms. Score the symptoms which apply to you as 0 (none), 1 (mild), 2 (moderate) or 3 (severe). score of 10 or higher in any one category (deficiency and excess combined is probably worthwhile to test.

Estrogens (Estradiol)

Estrogen Deficiency

- Hot Flashes
- Night Sweats
- Vaginal Dryness
- Foggy Thinking
- Memory lapses
- Incontinence
- Tearful
- Depressed
- Sleep Disturbance
- Heart Palpatation
- Bone Loss

Estrogen Excess

- Mood Swings
- Tender breasts
- Water retention
- Nervous
- Irritable
- Anxious
- Fibrocystic breasts
- Uterine fibroids
- Weight gain in hips
- Bleeding changes
- Headaches

Progesterone

Progesterone Deficiency

- Hot Flashes
- Night Sweats
- Vaginal Dryness
- Foggy Thinking
- Memory lapses
- Incontinence
- Tearful
- Depressed
- Sleep Disturbance
- Heart Palpatation
- Bone Loss

Progesterone Excess

- Sleepiness
- Breast swelling/tenderness
- Decreased Libido
- Mild Depression
- Candida infections (Yeast)

Androgens (DHEA and Testosterone)

Androgen Deficiency

- Low Libido
- Foggy Thinking
- Vaginal Dryness
- Fatigue
- Aches/pains
- Incontinence
- Memory Lapse
- Depressed
- Sleep Disturbance
- Decreased muscle mass
- Bone Loss
- Thinning Skin

Androgen Excess

- Excessive facial/body hair
- Loss of scalp hair
- Increased acne
- Oily skin

CORTISOL

Cortisol Deficiency

- Fatigue
- Sugar craving
- Allergies
- Chemical Sensitivity
- Stress
- Cold body temperature
- Heart palpitations
- Aches/pains
- Arthritis

Cortisol Excess

- Sleep disturbances
- Bone loss
- Fatigue
- Weight gain in waist
- Loss of muscle mass
- Thinning skin



INFORMED CONSENT

_____ I am participating in testosterone replacement of my own free will, at my expense and I fully understand that Dr. Debra Figueroa is not my Primary Care Physician and that is my responsibility to have annual labs and PSA and prostate checks.

_____ I also understand that testosterone replacement does not cause prostate cancer but it may exacerbate previously undetected prostate disease.

_____ I am aware of the potential benefits and side effects associated with testosterone.

_____ I hereby agree to answer truthfully all of the medical questions on my questionnaire or verbal consultation by a pharmacist or physician.

_____ I understand that no doctor, nurse, pharmacy, or administrative personnel can guarantee that testosterone replacement, even if prescribed, will provide the results I seek.

_____ I understand that life style modifications, weight loss, proper nutrition, vitamin/nutritional supplementation, adequate sleep and stress reduction are all key components to a successful testosterone replacement regimen.

Signed: _____ **Date:** _____

Print Name: _____

A signed informed consent must be received before prescriptions can be compounded and dispensed.

INFORMED CONSENT

_____ I am participating in bioidentical hormone replacement of my own free will, at my expense and I fully understand that Dr. Debra Figueroa is not my Primary Care Physician and that is my responsibility to have an annual physical exam, annual gynecological exam/breast exam/mammogram or equivalent.

_____ I fully understand that bio-identical hormone replacement potentially has the same cancer risk as the estrogen that my own body produces.

_____ I am aware of the potential benefits and side effects associated with natural/bioidentical hormone replacement.

_____ I hereby agree to answer truthfully all of the medical questions on my questionnaire or verbal consultation by a pharmacist or physician.

_____ I understand that no doctor, nurse, pharmacy, or administrative personnel can guarantee that testosterone replacement, even if prescribed, will provide the results I seek.

_____ I understand that life style modifications, weight loss, proper nutrition, vitamin/nutritional supplementation, adequate sleep and stress reduction are all key components to a successful bioidentical replacement regimen.

Signed: _____ Date: _____

Print Name: _____

A signed informed consent must be received before prescriptions can be compounded and dispensed.



Initial Consultation

Initial Consultation: \$50.00

Your initial visit will include a complete assessment of symptoms, history and physical. Prescription will be ordered.

1ST MONTH OF THERAPY:

Visit 1: \$50.00

At this visit, Dr. Debra Figueroa will initiate treatment.

Visit 2, 3 & 4: \$35.00 (each visit)

Includes topical medication and follow-up assessment of symptoms

2ND MONTH OF THERAPY

Visit 5: \$70.00

Includes symptom assessment

1 month supply of topical medication

**Based on evaluation of symptoms, Dr. Figueroa may require a saliva hormone test to evaluate your hormone level.*

3RD MONTH OF THERAPY

Visit 6: \$167.00:

Assessment of progress

Symptom free and stabilized on your dose you can purchase 3-month supply of medication.

6TH MONTH OF THERAPY

Visit 7: \$167.00

Assessment of progress

Symptom free and stabilized on your dose you can purchase 3-month supply of medication.

9th MONTH OF THERAPY

Visit 8: \$167.00

Assessment of progress, symptom free and stabilized on your dose you can purchase 3-month supply of medication.

** At some point during the first 3 months of therapy Dr. Figueroa may request you obtain a hormone saliva test. The Charge for this test is: \$150.00*

