Vital Flow PLLC

Penny Ingram, APRN

Women's Intake Form

Patient Name: _____ Date: _____

Address: _____DOB_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Do you understand the risks associated with the use of Biologically Identical Hormone Replacement, and that it is not our intention to go against your physician's advice. Do you understand that this is a cash pay practice, Medicare cannot be billed.

Name and contact details of emergency contact:_____

Do you understand what Biologically Identical Hormone Replacement is? _____

What are your goals for Biologically Identical Hormone Replacement?

_____

Family History	**(relationship)**
Cancer (type) _____	_____
Heart Disease	_____
Diabetes	_____
High Blood Pressure	_____
Osteoporosis	_____
Other	_____

Personal History

- ☐ Blood Clots
- ☐ Uterine Fibroids
- ☐ PCOS
- ☐ Smoking History
- ☐ Impaired Liver Function
- ☐ Fibrocystic Breasts
- ☐ AbnormaVag.Bleeding
- ☐ High blood pressure
- ☐ Stroke
- ☐ Thrombophlebitis
- ☐ Ovarian cysts
- ☐ Heart disease
- ☐ Diabetes
- ☐ Other _____
- ☐ Other _____

_____

☐Cancer (type) _____ Osteoporosis:_____ Any Rx for osteoporosis_____

Cholesterol Serum:_____Date:_____ Triglycerides:____ HDL:____ LDL:____ Chol/HDL Ratio:_____

Bone density scan results: _____Date: _____ Last Pap results:_____Date:_____

Current Health Care Provider/s:_____Co-vid vaccine:_____

To what degree do you experience the following? (0 – 5), 0 never, 5 frequently/daily

	1st appt	2nd appt	3rd appt	4th appt	5th appt
Difficulty Concentrating					
Can't Sleep (Insomnia)					
Depressed or Unhappy					
Anxious					
Headaches					
Moodiness/Emotional Swings					
Painful or Swollen Breasts					
Weight gain/ Bloating					
PMS					
Night Sweats					
Difficulty Remembering Things					
Brain Fog					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Incontinence					
Frequent Urinary Tract Infections					
Inability to Reach Orgasm					
Painful Intercourse					
Lack of Sexual Desire					
Fatigue/Loss of Energy					

General Health: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____ Do you exercise, describe:_____

Menstrual Cycle (history) : ☐ None ☐ Regular_____ ☐ Date of last period: _____

Irregular / Explain (heavy, how long, etc.): _____

☐ If no period, menstrual history (regular, irregular, days per month, days between)

Surgery: **Date of Surgery:** **Hospitalizations:**

☐ Oophorectomy _____ (ovaries) _____
☐ Hysterectomy _____ (uterus)
☐ Tubal Ligation
☐ Other_____
☐ None _____

Current Medications & Reason: Or attach

_____

_____

_____

Current Vitamins / Minerals / Herbal Formulas:

_____

_____

_____

Prior Hormone Replacement Therapy History: (include dates of use)

_____

Known Allergies (drug, food, pollen):

_____

Are you currently following a special diet (Gluten Free, Casien Free, Arkins, Paleo, Keto)

_____

Do you eat/drink soy: _____Caffeine/amount per day:_____ Alcohol/amount per day:_____

Notes and/or Questions:_____

It is recommended that baseline hormone levels be checked. This can be achieved by testing blood.

Women (For overall health check a,b, c and h yearly.)

a. Pap Smear
b. Thyroid: TSH, T3, and T4
c. Vitamin D3 (25 Hydroxy)
d. Testosterone (Free & Total)
e. Progesterone
f. Estradiol
g. DHEA (Sulfate)
h. Vitamin D

If you have recently (2 to 3 months) had a blood, urine, or saliva hormone or other hormone test, please attach the results to your questionnaire.

Privacy Agreement

Starting April 14, 2003, healthcare providers must comply with a new set of federal regulations. The regulations are part of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which addresses your rights to privacy and handling of Protected Health Information ("PHI").

Respect for your privacy is a top priority at Three Rivers Natural Medicine. Concern for your privacy rights goes hand in hand with our focus on maintaining and improving your health. One of the regulations requires that all our patients receive our Notice of Privacy Practices at the time of, or prior to, our providing healthcare services. We are also required to ask each patient to sign an acknowledgment indicating receipt of this notice.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ _____ _____

Patient Last Name Patient First Name M.I.

_____ _____

Patient's signature (or authorized representative) Date