Optimal Health Montana
Missoula, MT

406.223.0721
optimalhealthmt@gmail.com
www.ohm406.com

Disclosure: OHM always keeps your information private. However, we do not have encryption ability for your questionnaire. Please only fill in what you are comfortable with, knowing that we NEVER share your information!

HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

Name:______________________ Date of Birth:____________ Age: ______ Sex: ☐ Female ☐ Male

Address:______________________ City:______________ State:________ Zip:____________

Phone:______________ Email:____________________

Emergency Contact Name:____________________ Emergency Contact Phone:______________

How did you hear about us? ☐ Social Media:__________ ☐ Referral:__________ ☐ Internet Search ☐ Other:__________

What are your chief complaints and/or reasons for seeking HRT? Please check all that apply:

☐ Acne
☐ Bone Density Loss
☐ Brain Fog
☐ Constipation
☐ Decreased Libido
☐ Depression
☐ Difficulty Sleeping
☐ Difficulty Concentrating
☐ Dull/Dry Skin
☐ Dry Hair/Brittle Nails
☐ Fat Deposits
☐ Fatigue
☐ Fibromyalgia
☐ Hair Thinning/Loss
☐ Heat/Cold Intolerance
☐ Headache/Migraine
☐ Increased Stress
☐ Increased Wrinkles
☐ Joint Pain/Swelling
☐ Low Energy
☐ Low Mood
☐ Memory Issues
☐ Mood Swings
☐ Muscle Loss
☐ Night Sweats
☐ Saggy/Loose Skin
☐ Sore Muscles/Joints
☐ Urogenital Atrophy
☐ Vaginal Dryness
☐ Water Retention
☐ Weight Gain
☐ Weight Loss

Are there any other reasons you are seeking HRT not listed above? Please describe below:

____

____

Have you ever used Hormone Replacement Therapy (HRT) in the past? Check all that apply: ☐ Yes ☐ No

☐ Estrogen
☐ Estrogen Blocker
☐ Human Growth Hormone
☐ Oestrogen
☐ Progesterone
☐ Progestin
☐ Testosterone
☐ Tibolone

If you have ever used Hormone Replacement Therapy (HRT) in the past, please mark all forms you've tried:

☐ Buccal Tablet
☐ Creams (Topical)
☐ Gels (Topical)
☐ Injection (IM)
☐ Intravaginal Cream
☐ Intravaginal Tablet
☐ Intravaginal Ring
☐ Intrauterine Device
☐ Nasal Gel
☐ Oral Tablet
☐ Patch (Topical)
☐ Pellet (Implant)

List all previous HRT Dosages, Frequency, and Forms/Routes of Administrations

____

____

1- Do you have known allergies/sensitivities to:
☐ Adhesives ☐ Benzyl Alcohol ☐ Latex ☐ Lidocaine ☐ Topical Anesthetics

2- Have you ever had an allergic reaction to sutures/stitches? ☐ Yes ☐ No

3- Have you ever had an adverse reaction or significant side effects to HRT in the past? ☐ Yes ☐ No

If you marked an allergy above in line item 1 or marked yes to items 2-3 above, please explain below:

____

____

Do you have any surgical implants, screws, pins in treatment area(s)? ☐ Yes ☐ No

Do you currently take/use any medications that may cause increased risk of bleeding or delayed healing?
☐ Yes ☐ No

If yes, please check all that apply: ☐ Anti-Platelets ☐ Blood Thinners ☐ Corticosteroids ☐ NSAIDS

Female Medical History:

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Peri-menopausal

Current Birth Control:

☐ Abstinence	☐ Depo Provera	☐ Mirena/Copper	☐ Nexplanon	☐ Tubal Ligation
☐ Birth Control Pill	☐ Hysterectomy	☐ Menopause	☐ NuvaRing	☐ Vasectomy

☐ Other (Please Explain):______________________________

Date of Last Menses:__________ **Pregnancies:**__________ **Live Births:**__________

Pap Results/Date:__________ **Mammogram Results/Date:**__________

Are you experiencing or have you ever been diagnosed with any of the following:

☐ Blood Clots	☐ Breast Cancer (Family)	☐ Endometrial Cancer	☐ Vaginal Bleeding (Abnormal)
☐ Breast Cancer (Self)	☐ Ductal Hyperplasia (Breast)	☐ Uterine Fibroids	

General Medical History:

Date of last blood work:__________ **Date of last colorguard or colonoscopy:**__________

Describe any abnormal results:______________________________

____

Have you ever been diagnosed with or currently have:

☐ Angina/Chest Pain	☐ Congestive Heart Failure	☐ High Blood Pressure	☐ Neurological Disorder
☐ Arthritis/Rheumatism	☐ Diabetes	☐ High Cholesterol	☐ Orthopedic Disorder
☐ Asthma	☐ Emotional Disorder	☐ Immune Deficiency	☐ Poor Wound Healing
☐ Autoimmune Disorder	☐ Gallbladder Disease	☐ Kidney Disease	☐ Renal Insufficiency
☐ Blood Clotting Disorder	☐ Genitourinary Disorder	☐ Kidney Stones	☐ Stroke/TIAs
☐ Cancer	☐ Heart Attack	☐ Liver Disease	☐ Thyroid Issues
☐ Chemical Dependence	☐ Heart Disease	☐ Muscle Disorder	

Please explain any items you marked above:

____

____

Do you have any other medical issues not listed above? ☐ Yes ☐ No

If yes, please describe issue here:______________________________

Do you consume alcohol? ☐ Yes ☐ No

If yes, please list number of drinks you consume per week:

____

Do you smoke? ☐ Yes ☐ No

If yes, please describe how often and how much you smoke:

____

If there is anything else you'd like to share, please let us know here:

____

____

Patient Name: ______________________ DOB: ____________ Date: ____________

Medication Record

Please list medications, over the counter drugs, and herbal supplements you are currently taking. Please include any prescription topical creams and hormone replacement therapy medications/implants.

Medication or Supplement	*Frequency*	*Dose*	*Purpose/Prescribed For*

Allergies & Sensitivities

Do you have any allergies or sensitivities to foods, medications, implants, etc? ☐ Yes ☐ No

If yes, please list all allergens and how you react to them:

____

____

Surgical History

Have you been hospitalized or received acute medical care, including surgeries, in the past year? ☐ Yes ☐ No

If yes, please describe here: ____

Primary Care Physician: ______________________ **Phone:** ______________________

List surgical procedures you have had with approximate dates:

____

____

I affirm the information I have provided regarding my health history, medication record, and prior surgeries and aesthetic treatments is accurate to the best of my knowledge. I acknowledge that Optimal Health Montana staff is not responsible for any errors that may occur as a result of any omissions or incorrect information on this form. I acknowledge that OHM, Missy Miculka, is not a doctor, nor is she offering medical advice, I am responsible for my choices.

______________________ ______________________ ______________________

Patient Name (Print) **Patient Signature** **Date**