WHRT CHECKLIST

Aka: what we need to have before starting hormone replacement

- Mammogram within 1 year
- PAP within 3 years and normal
- Confirm no smoking tobacco use
- Discuss any personal history or family history of blood clots or breast cancer
- LABS
    - Blood count ($25)
    - Kidney and liver function ($45)
    - Cholesterol ($35)
    - Estradiol ($75)
    - Progesterone ($45)
    - Testosterone ($70)
    - Thyroid *optional ($25)

+ New patient visit ($99) or Follow-up visit ($79) and venipuncture fee ($15)

WHRT Patient Consultation

Patient Name: _____ Age: _____ Date: _____

BP (sitting):	Pulse:
Height (w/o shoes):	Weight (w/o shoes):

Date of last Pap smear: _____ normal/abnormal Last mammogram: _____ normal/abnormal

Date of last period: _____ Pregnant? _____ Breastfeeding? _____

Post-menopausal? _____ Hysterectomy or uterine ablation/year: _____

UTI or bladder/kidney infections in the last year? _____ Cancers? _____

Family history of breast cancer? _____ History of DVTs or blood clots? _____

OB/GYN: _____ PCP: _____

Are you currently taking birth control or hormones? Yes/No Please list: _____

_____

Please list any other medications you take: _____

_____

_____

Allergies: _____

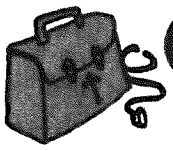
Symptoms:

	Severity:										
Trouble falling asleep	N/A	1	2	3	4	5	6	7	8	9	10
Trouble staying asleep	N/A	1	2	3	4	5	6	7	8	9	10
Anxiety or nervousness	N/A	1	2	3	4	5	6	7	8	9	10
Heavy vaginal bleeding	N/A	1	2	3	4	5	6	7	8	9	10
Headaches	N/A	1	2	3	4	5	6	7	8	9	10
Hot flashes	N/A	1	2	3	4	5	6	7	8	9	10
Night sweats	N/A	1	2	3	4	5	6	7	8	9	10
Loss of libido	N/A	1	2	3	4	5	6	7	8	9	10
Harder to reach climax	N/A	1	2	3	4	5	6	7	8	9	10
Fatigue	N/A	1	2	3	4	5	6	7	8	9	10
Irritability or mood swings	N/A	1	2	3	4	5	6	7	8	9	10
Vaginal dryness associated with intimacy	N/A	1	2	3	4	5	6	7	8	9	10
Recent memory loss	N/A	1	2	3	4	5	6	7	8	9	10
Belly fat weight gain	N/A	1	2	3	4	5	6	7	8	9	10
Lack of motivation	N/A	1	2	3	4	5	6	7	8	9	10
Urinary incontinence	N/A	1	2	3	4	5	6	7	8	9	10
Depression	N/A	1	2	3	4	5	6	7	8	9	10
Arthritis/achiness	N/A	1	2	3	4	5	6	7	8	9	10
Dry skin	N/A	1	2	3	4	5	6	7	8	9	10
Daily or constant vaginal dryness	N/A	1	2	3	4	5	6	7	8	9	10
Fluid retention	N/A	1	2	3	4	5	6	7	8	9	10
Hair loss	N/A	1	2	3	4	5	6	7	8	9	10

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐



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Consent for Hormone Replacement Therapy Program

I, _____ request from GracePointe Healthcare to prescribe for me Bioidentical Hormone Replacement Therapy (BHRT).

I understand that BHRT is not specifically approved by the FDA for preventative medicine and my request for BHRT is off-label.

I understand that the medical literature indicated that there may be health benefits to the use of BHRT and its long-term effects are undetermined.

I understand the risk/benefits as discussed pertaining to increased cancer and cardiovascular risk, but have chosen to pursue treatment.

I understand that GracePointe Healthcare cannot guarantee any results or that there will be no harm.

The potential health risks and benefits of using BHRT have been explained to me to my satisfaction.

I understand that BHRT is purely elective and that it may not be deemed medically necessary by insurance companies.

I certify that I have read the above consent and fully understand it.

I believe that I have adequate knowledge upon which to base this BHRT informed consent.

I fully understand what I am signing and hereby request and consent to BHRT Treatment.

Patient signature_____ Date____/____/_____

Physician signature_____ Date____/____/_____