WELLNESS BY EMCURA

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Women's Hormonal Health Intake Form

Patient Information

Name: _____ Date of Birth: _____

Date of Visit: _____Primary Reason for Visit: _____

Section 1: Reproductive & Hormonal History

Age of first period: _____

First day of last menstrual period (LMP): _____

Are your cycles regular? [ ] Yes [ ] No

Average length of cycle: _____ days

Are you currently:

[ ] Menstruating
[ ] Pregnant
[ ] Perimenopausal
[ ] Menopausal
[ ] Postmenopausal

Have you experienced any of the following?

[ ] Irregular periods
[ ] Painful periods
[ ] Heavy bleeding
[ ] PMS or PMDD
[ ] Hot flashes/night sweat
[ ] Vaginal dryness
[ ] Low libido
[ ] Mood swings
[ ] Infertility

Have you ever used or are currently using:

[ ] Birth control pills
[ ] IUD (hormonal or copper)
[ ] Bioidentical hormone therapy
[ ] Hormone replacement therapy (HRT)
[ ] Fertility treatments
Name of current gynecologist: _____
Date of last Pap smear: _____
Any history of abnormal Pap smears? [ ] Yes [ ] No

If yes, please describe: _____

Any history of HPV (Human Papillomavirus)? [ ] Yes [ ] No. If yes, please describe:_____

Section 2: Medical & Gynecological History

[ ] Endometriosis
[ ] PCOS
[ ] Uterine fibroids
[ ] Ovarian cysts
[ ] Breast cancer
[ ] Thyroid disorder
[ ] Osteopenia/Osteoporosis

Section 3: Symptoms & Wellness

Rate severity (0 = none, 5 = severe):

Fatigue: _____
Weight gain or difficulty losing weight: _____

Cold hands/feet: _____
Hair thinning: _____

Acne or oily skin: _____
Brain fog or memory issues: _____

Depression or anxiety: _____
Bloating or digestive issues: _____

Breast tenderness: _____
Sleep disturbances: _____

Section 4: Lifestyle Factors

Typical sleep per night: _____ hours
Do you feel rested upon waking? [ ] Yes [ ] No

Exercise routine: _____
Stress level (1–10): _____

Primary sources of stress: _____
Stress management: _____

Current diet:_____

Caffeine intake: _____ cups/day Alcohol intake: _____ drinks/week

Tobacco use: [ ] Never [ ] Former [ ] Current

Section 5: Medications & Supplements

Current medications: _____

Past or current hormonal medications: _____

Supplements used regularly: _____

Section 6: Goals

What are your top 2–3 goals for hormonal health?

_____

Are you open to exploring the following?

[ ] Bioidentical hormones
[ ] Herbal / natural hormone support
[ ] Nutritional support
[ ] Lifestyle interventions
[ ] Mind-body therapies

Section 7: Bioidentical Hormone Therapy – Information and Consent

Understanding the Benefits and Possible Risks

Hormone replacement therapy (HRT) can relieve symptoms of menopause, such as hot flashes, night sweats, mood changes, and vaginal dryness. It can also help protect bone health. Like any treatment, HRT has possible risks and side effects. This guide explains what you should know before and during therapy.

Blood & Heart Health INITIAL _____

- Small increase in risk of blood clots (deep vein thrombosis or pulmonary embolism)
- Slightly higher risk of stroke in some women
- Heart attack risk may increase in older women starting HRT many years after menopause
- Can cause swelling in legs or ankles (fluid retention)

Breast & Reproductive Health INITIAL _____

- Combined estrogen-progestin therapy may increase risk of breast cancer with long-term use
- Estrogen-only therapy lessens this risk but may increase risk of uterine (endometrial) cancer if the uterus is intact
- Can cause breast tenderness or swelling
- May cause irregular bleeding or spotting in the first months of use

Metabolism & Weight INITIAL _____

- Possible changes in cholesterol (may raise HDL but also triglycerides)
- May lead to weight gain from fluid retention
- Can affect blood sugar control in some women with diabetes

Skin & Hair INITIAL _____

- Skin irritation with patches or gels
- Hair thinning or increased facial hair in some women
- Improved skin hydration and elasticity for some

Mood & Brain Health INITIAL _____

- Can improve sleep, mood, and overall quality of life in many women
- Some women may notice mood swings or headaches
- Current evidence does not support HRT for memory or dementia prevention

Contraindications (check if any apply):

[ ] History of hormone-sensitive cancer (e.g., breast, uterine) [ ] History of blood clots or stroke

[ ] Liver disease [ ] Unexplained vaginal bleeding

[ ] Current pregnancy or breastfeeding

Do you have any of the conditions above? [ ] Yes [ ] No. If yes, please describe: _____

Consent:

I understand the benefits and potential risks of bioidentical hormone therapy.

I agree to discuss my treatment plan and follow-up regularly with my provider.

Signature: _____ Date: _____

Provider : _____ Date: _____