FEMALE PATIENT INTAKE FORM

First & Last Name: _____ Nickname: _____

Address: _____ _____

City: _____ State: _____ ZIP: _____

Contact Number: _____ Driver License Number: _____

Email: _____ _____

Occupation: _____

Height: _____ Current Weight: _____ Goal Weight: _____ BP (if known): _____

Birth Date: _____ Age: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Marital Status: Single ■ Married ■ Divorced ■ Widowed ■ Domestic Partnership ■

Primary Physician: _____ Date of Last Visit: _____

List Any Major Hospitalizations, Operations or Illness: _____ _____

Primary Symptoms / Concerns:

FAMILY HISTORY INFORMATION — CHECK ALL THAT APPLY

■ Abnormal Blood Pressure
■ Arthritis / Joint Problems
■ Asthma / Bronchitis
■ Autoimmune Disease
■ Blood Disorders / Anemia
■ Cancer / Tumors / Cysts
■ Colitis
■ Crohn's Disease
■ Depression / Mental Illness
■ Diabetes
■ Eczema / Psoriasis
■ Endocrine Disorder
■ Epilepsy
■ Excessive Bleeding
■ Gallstones
■ Heart Disease
■ Herpes / Cold Sores
■ HIV
■ Hepatitis
■ Liver Disease
■ Kidney Infections / Stones
■ Emphysema
■ Melanoma / Skin Cancer
■ Pneumonia
■ Reoccurring Infections
■ Rheumatic Fever
■ Rheumatoid Arthritis
■ Thyroid Disease
■ Tuberculosis
■ Seizures
■ Stroke
■ Ulcers
■ Yeast Infections (Chronic)

List Current RX Medications:

_____

Check All That Apply:

■ Bloating
■ Reflux
■ Constipation
■ Hemorrhoids
■ Bowel Habit Changes
■ Coughing / Wheezing
■ Allergies
■ Salt Cravings
■ Sugar Cravings
■ Alcohol Cravings
■ Hair Loss
■ Dry Hair
■ Thinning Hair
■ Nausea
■ Dizziness
■ Fatigue
■ Trouble Sleeping
■ Morning Swelling
■ Cold Hands / Feet
■ Poor Circulation
■ Low Energy
■ Joint Pain
■ Sensitive to Cold
■ Palpitations
■ Insomnia
■ Acne
■ Dry Skin
■ Arthritis Pain
■ Back Pain
■ Depression
■ Anxiety

FEMALE HORMONE HISTORY

Date of Last Period: _____

Are Your Menstrual Cycles: 21 Day ■ 28 Day ■ 31 Day ■ Irregular ■

Are You Currently Pregnant? Yes ■ No ■

Total Pregnancies: _____ Living: _____ Miscarriages: _____

Last Date of PAP Smear: _____

Last Date of Mammogram: _____

Have You Used Oral Contraceptives? Yes ■ No ■ Age Started: _____ Age Stopped: _____

Explain Any Issues: _____

Have You Had Breast Cancer? Yes ■ No ■

When:

_____

Have You Had Ovarian Cancer? Yes ■ No ■

Have You Had Uterine Fibroids? Yes ■ No ■

Have You Had a Hysterectomy? Yes ■ No ■ Ovaries Removed? Yes ■ No ■

Reason for Surgery: _____

Date of Surgery: _____

HEALTH INFORMATION AUTHORIZATION (HIPAA)

I authorize ApexLife Rejuvenation to disclose my medical records for the purpose of: Bio-identical Hormone Therapy, Menopause Treatment, Weight Loss, Stress Management, and Telehealth. I understand I may revoke this authorization at any time.

Patient Signature: _____ Date: _____

THERAPY & MEDICATION MANAGEMENT AGREEMENT

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Patient Signature: _____ Date: _____

DISCLOSURES AND WAIVERS

Before therapy can be provided, the following are required: 1. Updated bloodwork 2. A recent physical 3. Medication history review

Patient Signature: _____ Date: _____

PHYSICAL EXAMINATION FORM

To be completed by Physician.

Working DX: _____

Conduct & Assessment:

_____
_
_____
_
_____
_

PHYSICAL EXAMINATION — SYSTEMS CHECK

■ Skin — Describe: _____

■ HEENT — Describe: _____

■ Neck — Describe: _____

■ Breasts — Describe: _____

■ Lungs — Describe: _____

■ Heart — Describe: _____

■ Abdomen — Describe: _____

■ Genitalia — Describe: _____

■ Rectal — Describe: _____

■ Neuro — Describe: _____

■ Psych — Describe: _____

■ Extremities — Describe: _____

Physician Signature: _____ Date: _____