



# Hormone Care Pre Consultation Form

## Medical intake, laboratory review, contraindication screening, and informed consent

Complete this form before your consultation. Your answers help the clinician evaluate safety and medical appropriateness. Completing or signing this form does not guarantee that treatment will be prescribed.

### Patient Information

Full legal name

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Date of birth

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Phone

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Email

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Sex assigned at birth

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Gender identity if relevant

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### Type of Evaluation Requested

- |                                                                |                                                                |
|----------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Testosterone evaluation               | <input type="checkbox"/> Perimenopause or menopause evaluation |
| <input type="checkbox"/> Menstrual or ovarian hormone concerns | <input type="checkbox"/> Sexual symptoms                       |
| <input type="checkbox"/> Other                                 |                                                                |

### Current symptoms

- |                                                          |                                                            |
|----------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Fatigue                         | <input type="checkbox"/> Reduced libido                    |
| <input type="checkbox"/> Erectile changes                | <input type="checkbox"/> Hot flashes or night sweats       |
| <input type="checkbox"/> Sleep disturbance               | <input type="checkbox"/> Mood changes                      |
| <input type="checkbox"/> Reduced strength or muscle mass | <input type="checkbox"/> Weight or body-composition change |
| <input type="checkbox"/> Irregular or absent periods     | <input type="checkbox"/> Vaginal dryness or discomfort     |
| <input type="checkbox"/> Hair or skin changes            | <input type="checkbox"/> Other                             |

Describe your symptoms, when they began, and how they affect you

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### Reproductive and Hormone History

- |                                                                |                                                         |
|----------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Pregnant or possibly pregnant         | <input type="checkbox"/> Trying to conceive             |
| <input type="checkbox"/> Breastfeeding                         | <input type="checkbox"/> Future fertility is important  |
| <input type="checkbox"/> Prior hysterectomy                    | <input type="checkbox"/> Prior removal of ovaries       |
| <input type="checkbox"/> Prior prostate condition or procedure | <input type="checkbox"/> Current hormonal contraception |
| <input type="checkbox"/> Current or prior hormone therapy      |                                                         |

Current and prior hormone products, doses, benefits, and side effects

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## Medical Safety Screening

- |                                                                                                    |                                                                           |
|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Breast, endometrial, ovarian, prostate, or other hormone-sensitive cancer | <input type="checkbox"/> Unexplained vaginal bleeding                     |
| <input type="checkbox"/> Blood clot, pulmonary embolism, or clotting disorder                      | <input type="checkbox"/> Stroke or transient ischemic attack              |
| <input type="checkbox"/> Heart attack, coronary disease, or heart failure                          | <input type="checkbox"/> Liver disease                                    |
| <input type="checkbox"/> High hematocrit or polycythemia                                           | <input type="checkbox"/> Untreated or severe sleep apnea                  |
| <input type="checkbox"/> Severe urinary symptoms or elevated PSA                                   | <input type="checkbox"/> Migraine with aura                               |
| <input type="checkbox"/> Seizure disorder                                                          | <input type="checkbox"/> Gallbladder disease                              |
| <input type="checkbox"/> Infertility                                                               | <input type="checkbox"/> Current tobacco or nicotine use                  |
| <input type="checkbox"/> Pregnancy or breastfeeding                                                | <input type="checkbox"/> Allergy or serious reaction to a hormone product |

**Explain every item checked above**

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**List all medications, supplements, allergies, and relevant family history**

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## Recent Results Available

Upload available results with collection dates. The clinician will determine which tests are appropriate; this list is not a standing order for every patient.

### Testosterone pathway

- |                                                                               |                                                            |
|-------------------------------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Two separate early-morning total testosterone levels | <input type="checkbox"/> Free testosterone or SHBG         |
| <input type="checkbox"/> CBC and hematocrit                                   | <input type="checkbox"/> PSA when age and risk appropriate |
| <input type="checkbox"/> CMP or liver tests                                   | <input type="checkbox"/> A1c or fasting glucose            |
| <input type="checkbox"/> Lipid panel                                          | <input type="checkbox"/> LH and FSH                        |
| <input type="checkbox"/> Prolactin                                            | <input type="checkbox"/> TSH                               |

### Perimenopause, menopause, or ovarian pathway

- |                                                                      |                                                              |
|----------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Pregnancy test if applicable                | <input type="checkbox"/> CBC                                 |
| <input type="checkbox"/> CMP or liver tests                          | <input type="checkbox"/> A1c or fasting glucose              |
| <input type="checkbox"/> Lipid panel                                 | <input type="checkbox"/> TSH                                 |
| <input type="checkbox"/> FSH and estradiol when clinically indicated | <input type="checkbox"/> Prolactin when clinically indicated |
| <input type="checkbox"/> Recent mammogram information                | <input type="checkbox"/> Cervical screening information      |

**Date of most recent labs**

**Where completed**

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## Compounded Medication Assessment

- |                                                                                                                          |                                                                                       |
|--------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| <input type="checkbox"/> Documented allergy or intolerance to an inactive ingredient                                     | <input type="checkbox"/> Clinically necessary strength not commercially available     |
| <input type="checkbox"/> Clinically necessary dosage form not commercially available                                     | <input type="checkbox"/> Clinically necessary combination determined by the clinician |
| <input type="checkbox"/> Available FDA-approved product is not medically appropriate for another patient-specific reason | <input type="checkbox"/> No patient-specific reason identified                        |

### Describe the specific patient need

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## Patient Acknowledgment and Consent

Please initial each statement in Vagaro or select each required acknowledgment before signing.

- ☐ I understand hormone treatment is prescribed only for an appropriate diagnosis after review of symptoms, history, examination, and relevant testing. A laboratory value alone does not guarantee treatment.
- ☐ If testosterone is prescribed, I understand possible risks include acne, oily skin, hair loss, breast tenderness, swelling, mood or libido changes, reduced sperm production and fertility, testicular shrinkage, increased red blood cell concentration, worsening sleep apnea or urinary symptoms, and uncertain cardiovascular or prostate-related risks. Testosterone is a controlled substance.
- ☐ If estrogen or progestogen is prescribed, I understand risks vary by product, dose, route, age, and history and may include bleeding, breast tenderness, headache, mood change, gallbladder disease, blood clots, stroke, cardiovascular events, and changes in breast or endometrial cancer risk. Estrogen requires appropriate endometrial protection when a uterus is present unless the clinician documents otherwise.
- ☐ I will report chest pain, shortness of breath, one-sided leg swelling, neurologic symptoms, severe headache, jaundice, pregnancy, new breast changes, or unexplained vaginal bleeding promptly or seek emergency care when appropriate.
- ☐ I understand compounded hormone products are not FDA approved and are not routinely preferred when an appropriate FDA-approved product can meet my needs. Compounded products may have variability, contamination, dosing, and effectiveness risks.
- ☐ I understand alternatives include treating another identified cause, nonhormonal therapy, FDA-approved hormone formulations when appropriate, specialist referral, or no treatment. Benefits are not guaranteed and ongoing monitoring is required.

## Signatures

By signing, I confirm that I have read this form, answered truthfully, had an opportunity to ask questions, and voluntarily consent to the evaluation and any treatment specifically ordered after consultation. I may decline or withdraw consent before treatment. I understand that this acknowledgment does not waive rights that cannot legally be waived or excuse negligent or unlawful conduct.

Patient full legal name

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Patient signature

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Date of birth

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Date and time

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If signed by a legally authorized representative:

Representative name

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Relationship or authority

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Representative signature \_\_\_\_\_

Date and time \_\_\_\_\_

## Clinician Use Only

☐ Consultation completed in person

☐ Consultation completed by telehealth

☐ Identity verified

☐ Medication reconciliation completed

Blood pressure \_\_\_\_\_

Heart rate \_\_\_\_\_

Weight \_\_\_\_\_

BMI \_\_\_\_\_

### Pertinent history, examination, and assessment

\_\_\_\_\_  
\_\_\_\_\_

### Diagnosis or treatment indication

\_\_\_\_\_

☐ Not a candidate

☐ Additional records or testing required

☐ Candidate after shared decision-making

☐ Referred for additional evaluation

### Patient-specific medical necessity and rationale for any compounded preparation

\_\_\_\_\_  
\_\_\_\_\_

### Selected medication, formulation, dose, monitoring plan, and follow-up

\_\_\_\_\_  
\_\_\_\_\_

I independently reviewed the information above, completed an appropriate clinical evaluation, discussed material risks, benefits, alternatives, and uncertainties, and determined whether hormone therapy is medically appropriate. The patient form alone was not used as a substitute for clinical judgment.

Clinician name and credentials \_\_\_\_\_ Clinician signature \_\_\_\_\_ Date and time \_\_\_\_\_