



Female HRT | Symptom & Health Intake

Please complete all applicable questions before your appointment.

PATIENT INFORMATION

Full name

Date of birth

Phone

Email

SYMPTOMS - CHECK ALL THAT APPLY

☐ Fatigue / low energy

☐ Low libido

☐ Hot flashes

☐ Night sweats

☐ Mood swings

☐ Anxiety

☐ Depression / low mood

☐ Brain fog / memory

☐ Poor sleep

☐ Weight gain

☐ Hair thinning

☐ Vaginal dryness

☐ Irregular periods

☐ Reduced muscle strength

☐ Headaches

☐ Other symptoms

SLEEP AND REPRODUCTIVE GOALS

Sleep apnea diagnosed?

☐ Yes

☐ No

If yes, do you use CPAP / BiPAP?

☐ CPAP

☐ BiPAP

☐ Neither

Do you want children in the future?

☐ Yes

☐ No

☐ Unsure

If yes, are you actively trying to conceive?

☐ Yes

☐ No



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Medical, medication and lifestyle history

HORMONE THERAPY AND SUPPLEMENTS

Are you currently on TRT or other hormone therapy?

☐ Yes

☐ No

If yes, how long have you been on it?

Testosterone dose (mg per week), if applicable

Do you take testosterone boosters?

☐ Yes

☐ No

If yes, list product(s)

Do you take supplements?

☐ Yes

☐ No

If yes, list supplements and doses

LIFESTYLE AND OTHER HEALTH INFORMATION

Do you drink alcohol?

☐ Yes

☐ No

If yes, how often?

Current medications / other medical concerns

Primary goals for treatment



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Patient acknowledgement

PATIENT ACKNOWLEDGEMENT AND SIGNATURE

I confirm that the information provided is accurate to the best of my knowledge.

Typed signature (or use your PDF reader's signature tool to sign):

Signature

Date

Note: A typed name is not a cryptographic digital signature.

For privacy, return through your clinic's secure patient portal.