Aislinn Medical Spa

Female Hormone Therapy Consultation

Patient Name: _____ DOB: _____ Date: _____

Patient Concerns: _____

Patient History:

- □ Breast Cancer
- □ Endometrial Cancer
- □ Relative w/ Breast/Endometrial Cancer
- □ Breast Biopsy
- □ Endometrial Ablation
- □ Fibroids or Polyps
- □ Unexplained Vaginal Bleeding
- □ Currently Pregnant or planning to be
- □ Smoker - Current or History
- □ Polycythemia
- □ Current or HX of Blood Clots (Thrombosis)
- □ High Blood Pressure (Hypertension)
- □ Atherosclerosis
- □ Stroke
- □ Taking Blood Thinners
- □ Liver Disease
- □ Diabetes
- □ Pituitary Tumor
- □ Other _____

_____ Date of Last Mammogram

_____ Date of Last Vaginal Exam

_____ Date of Last Annual Exam

Allergies

Medications:

Physical Exam:

B/P: HR: RR: Temp: HT: WT: BMI:

General:

HEENT:

Neck:

Cardiovascular:

Respiratory:

GI:

GU:

Musculoskeletal:

Neuro:

Skin:

Diagnosis: _____

Treatment Plan:

Labs: □FSH □Estradiol □Progesterone □Total Testosterone □CBC □Hepatic Function Panel □IGF

Provider Signature: Date: