

HORMONE CONSULT INTAKE FORM

**Nancy Siskowic, NP, CNS-BC**  
Nurse Practitioner Women's Health ~ Menopause Clinician  
Psychotherapist  
36 Malaga Cove Plaza #203  
Palos Verdes Estates CA, 90274  
Phone: 310-872-4640 Fax: 310-375-8415  
[nsiskowic@cox.net](mailto:nsiskowic@cox.net)  
[www.nancysiskowic.com](http://www.nancysiskowic.com)

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Health Care Provider: \_\_\_\_\_

Gynecologist: \_\_\_\_\_

~~~~~  
Office Use only:

CPT: \_\_\_\_\_ DX: \_\_\_\_\_

Billing Dates \_\_\_\_\_

\_\_\_\_\_  
PAP \_\_\_\_\_ MAMO \_\_\_\_\_

## HORMONE SYMPTOM CHECK LIST

Prepared by Nancy Siskowic, NP, CNS-BC  
 Nurse Practitioner Women's Health ~ Psychotherapist  
 310-872-4640 [www.nancysiskowic.com](http://www.nancysiskowic.com) Revised 3/2/19

|                                                                 |                      |                        |                         |                                   |   |
|-----------------------------------------------------------------|----------------------|------------------------|-------------------------|-----------------------------------|---|
| Name _____                                                      | Age _____            | Date _____             |                         |                                   |   |
| <b>In the past month have I experienced?"</b>                   | <b><u>0</u> = no</b> | <b><u>1</u> = some</b> | <b><u>2</u> = often</b> | <b>Is this a problem for you?</b> |   |
|                                                                 |                      |                        |                         | Y                                 | N |
| <b>Hot flashes - night sweats...kicking covers off feet</b>     | 0                    | 1                      | 2                       | Y                                 | N |
| Sleep disturbance...frequent awakening or mind racing           | 0                    | 1                      | 2                       | Y                                 | N |
| Fatigue, weakness                                               | 0                    | 1                      | 2                       | Y                                 | N |
| Memory loss, foggy thinking.                                    | 0                    | 1                      | 2                       | Y                                 | N |
| Depression, Irritability, mood swings, tension                  | 0                    | 1                      | 2                       | Y                                 | N |
| Easily tearful                                                  | 0                    | 1                      | 2                       | Y                                 | N |
| Wanting to be left alone...isolating behavior                   | 0                    | 1                      | 2                       | Y                                 | N |
| Anxiety, panic that comes and goes                              | 0                    | 1                      | 2                       | Y                                 | N |
| Heart palpitations, light-headed or dizzy ( <u>circle</u> )     | 0                    | 1                      | 2                       | Y                                 | N |
| Chest pressure or pain, shortness of breath                     | 0                    | 1                      | 2                       | Y                                 | N |
| Lost days from work                                             | 0                    | 1                      | 2                       | Y                                 | N |
| Bloating, flatulence (gas)                                      | 0                    | 1                      | 2                       | Y                                 | N |
| Muscle or joint aches and pains                                 | 0                    | 1                      | 2                       | Y                                 | N |
| Hair loss, dry skin, nose bleeds, facial hair ( <u>circle</u> ) | 0                    | 1                      | 2                       | Y                                 | N |
| Skin 'crawling', sensitivity to touch, numbness                 | 0                    | 1                      | 2                       | Y                                 | N |
| Migraines (more frequent).                                      | 0                    | 1                      | 2                       | Y                                 | N |
| Weight gain (esp. mid body).                                    | 0.                   | 1.                     | 2                       | Y                                 | N |
| Occasional extreme breast tenderness                            | 0                    | 1                      | 2                       | Y                                 | N |
| Vaginal dryness, itching, burning                               | 0                    | 1                      | 2                       | Y                                 | N |
| Pain with intercourse                                           | 0                    | 1                      | 2                       | Y                                 | N |
| Lessened sexual desire, drive, activity                         | 0                    | 1                      | 2                       | Y                                 | N |
| Difficulty achieving orgasm                                     | 0                    | 1                      | 2                       | Y                                 | N |
| Frequent vaginal / urinary tract infections                     | 0                    | 1                      | 2                       | Y                                 | N |
| Leaking urine with cough, sneeze, laugh, exercise               | 0                    | 1                      | 2                       | Y                                 | N |
| Leaking urine with strong sudden urge                           | 0                    | 1                      | 2                       | Y                                 | N |

Which of the above is/are most problematic for you? \_\_\_\_\_

Other symptoms? \_\_\_\_\_

**What is the reason for your visit?**

**What questions or concerns would you like addressed during your appointment?**

**Do you have concerns / fears about menopause / hormone therapy?**

**Please list any major illnesses, injuries, surgeries or hospitalizations (excluding pregnancy).**

**Does your medical history include any of the following (please underline all that apply)**

|                                    |                               |
|------------------------------------|-------------------------------|
| <b>Migraines</b>                   | <b>Colitis</b>                |
| <b>High Blood Pressure</b>         | <b>Diarrhea</b>               |
| <b>Stroke</b>                      | <b>Constipation</b>           |
| <b>High Cholesterol</b>            | <b>Bloody or Black Stools</b> |
| <b>Heart Attack</b>                | <b>Hepatitis</b>              |
| <b>Easy Bruising</b>               | <b>Liver Disease</b>          |
| <b>Blood Clots</b>                 | <b>Gallbladder Disease</b>    |
| <b>Anemia</b>                      | <b>Breast Biopsies</b>        |
| <b>Indigestion</b>                 | <b>Endometriosis</b>          |
| <b>Frequent Nausea or Vomiting</b> | <b>Fibroids</b>               |
| <b>Diabetes</b>                    | <b>Teeth or Gum Problems</b>  |
| <b>Thyroid</b>                     | <b>Frequent Falling</b>       |
| <b>Asthma</b>                      | <b>Losing Height</b>          |
| <b>Arthritis</b>                   | <b>Broken Bones</b>           |
| <b>Back pain</b>                   | <b>Weight</b>                 |
| <b>Seizures</b>                    | <b>Cancer</b>                 |
| <b>Macular Degeneration</b>        | <b>Infertility</b>            |
| <b>Cataracts</b>                   | <b>Suicidal Thoughts</b>      |

**Other...**

**What is the date of your last...**

**Pap smear: \_\_\_\_\_ Any abnormal Pap tests? \_\_\_\_\_**

**Mammogram: \_\_\_\_\_ Chemistry Panel: \_\_\_\_\_**

**Bone Density Test: \_\_\_\_\_ Colonoscopy: \_\_\_\_\_**

**Family History:**

Please list family member(s) who have the following...

High blood pressure

Heart attack

Stroke

Blood clots

Glaucoma

Diabetes

Osteoporosis

Hip fracture

Breast cancer

Ovarian cancer

Colorectal cancer

Alzheimer's / Dementia

Alcoholism

Depression

Is there anything about your family's health history that you would like to discuss?

**Obstetrical and Gynecologic History:**

Are you currently using birth control? \_\_\_\_\_ What method? \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ How many children do you have? \_\_\_\_\_

Your age at the birth of your first child: \_\_\_\_\_ At the birth of your last child: \_\_\_\_\_

Any complication during pregnancy, delivery or post partum? \_\_\_\_\_

Age at First Menstrual Period: \_\_\_\_\_

Last Menstrual Period: \_\_\_\_\_

:

If you are still having periods...

Are they regular? \_\_\_\_\_ How many days do they last? \_\_\_\_\_

Do you have spotting or bleeding in between? \_\_\_\_\_

Has there been a recent change? Explain...

Do you have problems with PMS?

Are you currently sexually active?

Do you have concerns about your sex life?

Are you allergic to any medications? \_\_\_\_\_ If yes please list which ones and your reaction...

Do you have any other allergies? \_\_\_\_\_ If yes please indicate to what, and your reaction...

Are you currently using hormone therapy for menopause?

Please list all medications and supplements (over the counter) you are currently taking...

| NAME | DOSE | FREQUENCY | HOW LONG |
|------|------|-----------|----------|
|      |      |           |          |
|      |      |           |          |
|      |      |           |          |
|      |      |           |          |
|      |      |           |          |
|      |      |           |          |
|      |      |           |          |
|      |      |           |          |
|      |      |           |          |

Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_

What do you do? \_\_\_\_\_

Do you consider your diet excellent \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ How many per day \_\_\_\_\_ Do you want to quit \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How many drinks each week? \_\_\_\_\_ Do you feel a need to cut down on you drinking \_\_\_\_\_ Do you use recreational drugs? \_\_\_\_\_

Within the last year have you experienced emotional, physical or sexual abuse? \_\_\_\_\_

What are your current major stressors or life changes? \_\_\_\_\_

Any major changes in family health in the past year? \_\_\_\_\_

How do you handle stress? \_\_\_\_\_

What do you do to relax? \_\_\_\_\_

**Nancy Siskowic, NP, CNS  
36 Malaga Cove Plaza # 203  
Palos Verdes Estates  
CA, 90274**

### **Limits of Confidentiality Statement**

Whatever we talk about, I will hold in strictest confidence. There are some legal exceptions to this:

- If you authorize a release of information with a signature.
- If your mental condition becomes an issue in a law suit.
- If you present as a physical danger to yourself (Johnson v county of Los Angeles, 1983)
- If you present as a danger to others (Tarasoff v Regents of University of California, 1967)
- If child or elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes)

In the latter two cases, I am required by law to inform potential victims, protective agencies, and/or legal authorities so that protective measures may be taken.

### **Payment for Services**

Payments are due and payable at each appointment. If you plan to utilize your insurance benefits, you are responsible for obtaining prior authorization for treatment. **SUPER BILLS WILL BE PROVIDED AT THE END OF EACH MONTH FOR SUBMISSION TO YOUR HEALTH INSURANCE COMPANIES.**

### **Cancellation & Missed Appointment Policy**

Scheduled appointment times are reserved especially for you. If you miss or cancel an appointment with less than 24 hours notice, you will be responsible for the fee. Your insurance will not be billed for fees associated with missed or cancelled appointments.

### **Prescriptions and Refills**

Refills can be handled by fax. Please allow 3 days for all refill requests. When you have a week remaining on your prescription, contact your pharmacy and request a refill. If you are not current with your appointments, refill requests may be denied.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_