ROCKY MOUNTAIN HORMONE & WEIGHT LOSS CLINIC
7853 E. Arapahoe Court, Suite 2600 • Centennial, CO 80112 • 303-917-7177

NEW PATIENT INTAKE & HEALTH HISTORY

Please complete all applicable sections. Bring current medication/supplement lists and recent lab results if available.

1. PATIENT INFORMATION

Legal Name _____ Preferred Name _____

Date of Birth _____ Age _____

Pronouns _____ Sex Assigned at Birth _____

Phone _____ Email _____

Home Address _____ City / State / ZIP _____

Occupation _____ Marital / Relationship Status _____

☐ I give permission for the clinic to leave appointment or billing messages at the phone number above.
☐ I prefer communication by: ☐ Phone ☐ Text ☐ Email ☐ Patient Portal

2. EMERGENCY CONTACT

Name _____ Relationship _____

Phone _____ Alternate Phone _____

3. REASON FOR TODAY'S VISIT

☐ Hormone evaluation / replacement therapy (BHRT)
☐ Weight management / metabolic health
☐ Fatigue / low energy
☐ Menopause / perimenopause symptoms
☐ Low testosterone / men's health
☐ Sexual health / libido concerns
☐ Other: _____
Main concerns / goals: _____
_____

4. MEDICAL HISTORY

☐ High blood pressure
☐ High cholesterol
☐ Diabetes / prediabetes
☐ Thyroid disorder
☐ Heart disease / chest pain / arrhythmia
☐ Blood clot / DVT / pulmonary embolism
☐ Stroke / TIA
☐ Kidney disease
☐ Liver disease
☐ Sleep apnea
☐ Migraine
☐ Depression / anxiety / other mental health condition
☐ Cancer or history of cancer
☐ Seizures
☐ Gallbladder / pancreatitis

☐ Other: _____
Other relevant medical conditions: _____
_____

5. SURGERIES / HOSPITALIZATIONS

Surgeries / procedures and dates: _____
_____
_____
Hospitalizations / reason / dates: _____
_____

6. ALLERGIES

☐ No known drug allergies
☐ Medication allergy
☐ Food allergy
☐ Latex allergy
Allergies and reactions: _____
_____

7. MEDICATIONS & SUPPLEMENTS

List prescription medications, over-the-counter medications, vitamins, supplements, hormones, peptides, and injections currently used.

Medication / Supplement	Dose	How Often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. WOMEN'S HORMONE & REPRODUCTIVE HISTORY (if applicable)

Last Menstrual Period (LMP) _____

Age at First Period _____

Cycle Length _____

Age at Menopause, if applicable _____

☐ Pregnant now
☐ Trying to become pregnant
☐ Breastfeeding
☐ History of infertility
☐ Hysterectomy
☐ Ovaries removed (oophorectomy)
☐ Endometriosis / fibroids
☐ Current or prior birth control
☐ Current or prior estrogen, progesterone, testosterone, DHEA or other hormone therapy

Pregnancy / childbirth history (G/P or number of pregnancies/births): _____

_____

Breast/gynecologic history, including abnormal mammogram/Pap or breast/ovarian cancer history: _____

_____

9. MEN'S HORMONE HISTORY (if applicable)

☐ Previous testosterone therapy
☐ Current testosterone therapy
☐ Fertility concerns
☐ Prostate disorder / elevated PSA
☐ Erectile dysfunction
☐ Decreased libido
☐ Testicular surgery or injury
☐ History of anabolic steroid use

Prior testosterone products, dose, and approximate dates: _____

_____

Most recent testosterone / PSA labs and dates, if known: _____

_____

10. WEIGHT & METABOLIC HEALTH

Height _____

Current Weight _____

Usual Weight _____

Goal Weight _____

Highest Adult Weight _____

Lowest Adult Weight _____

☐ Previous weight-loss medications
☐ Previous GLP-1 / GIP medication
☐ Previous diet program / nutrition counseling
☐ Previous bariatric surgery
☐ History of eating disorder
☐ Family history of diabetes / obesity

Prior weight-loss medications and results / side effects: _____

_____

11. LIFESTYLE

Tobacco / nicotine use _____

Alcohol use _____

Exercise / activity _____

Typical sleep hours/night _____

Typical diet / eating pattern: _____

Stress level and major stressors: _____

12. REVIEW OF SYMPTOMS

☐ Fatigue / low energy
☐ Hot flashes / night sweats
☐ Weight gain / difficulty losing weight
☐ Hair loss / thinning
☐ Acne / oily skin
☐ Mood changes / irritability
☐ Poor sleep
☐ Brain fog / memory concerns
☐ Decreased libido
☐ Erectile or sexual function concerns
☐ Irregular periods
☐ Vaginal dryness / pain with intercourse
☐ Urinary symptoms
☐ None of the above

13. FAMILY HISTORY

☐ Heart disease
☐ Stroke
☐ Diabetes
☐ High cholesterol
☐ Thyroid disease
☐ Blood clots
☐ Breast cancer
☐ Ovarian cancer
☐ Prostate cancer
☐ Other significant family history: _____

14. RECENT LABS / SCREENING

☐ I have recent lab results and will provide them to the clinic.
☐ Please order/review labs as clinically appropriate.
Recent labs, dates, or outside providers/facilities: _____

15. PATIENT ACKNOWLEDGMENT

I certify that the information I have provided is true and complete to the best of my knowledge. I understand that I should notify the clinic of changes in my medications, medical conditions, pregnancy status, or other relevant health information. I understand that treatment recommendations are based on my history, examination, laboratory findings, and clinical judgment. I have had an opportunity to ask questions about my care.

☐ I understand and agree to the above acknowledgment.

Patient / Authorized Representative Signature _____ Date _____

Printed Name _____ Relationship, if applicable _____

16. CLINIC USE ONLY

Date Received	Provider	Visit Type	Follow-Up Date
_____	_____	_____	_____
BP	Pulse	Weight	BMI
_____	_____	_____	_____
Labs Ordered	Labs Reviewed	Medication/Plan	Notes
_____	_____	_____	_____