CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date: _____

Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____
Street City State Zip

Phone: _____ **Email:** _____

Height: _____ Weight: _____ Desired Weight: _____

			How Often and how much?
Do you use tobacco?	☐ Yes	☐ No	_____
Do you use alcohol?	☐ Yes	☐ No	_____
Do you use caffeine?	☐ Yes	☐ No	_____
Do you exercise?	☐ Yes	☐ No	_____

Allergies: Please list any allergies and describe the reaction that occurred
Drugs: _____
Foods: _____
Other: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements): _____
_____
_____
_____
_____
_____
_____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc).
_____
_____
_____

Current Prescription Medications (including hormones):

Medication Name and Strength	Date Started	How Often per day
_____		
_____		
_____		
_____		
_____		

Patient Name: _____

List Hormones Previously Taken: Date Started Date Stopped Reason

_____

_____

_____

_____

Have you ever used oral contraceptives (birth control)? ☐ Yes ☐ No

If you experienced any problems, please describe: _____

_____

How many pregnancies have you had? _____ How many children? _____

Any Interrupted pregnancies? ☐ Yes ☐ No

If yes, please explain:_____

Have you had a tubal ligation: ☐ Yes ☐ No If yes, date of surgery: _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, date of surgery: _____

Reason: _____ Do your ovaries remain? ☐ Yes ☐ No

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

_____

_____

_____

Have you had any of the following tests performed?

Mammography	☐ Yes ☐ No	Date: _____	Outcome: _____
PAP Smear	☐ Yes ☐ No	Date: _____	Outcome: _____
Bone Density	☐ Yes ☐ No	Date: _____	Outcome: _____

What age did your period start? _____ How many days is/was your cycle (Example: 28): _____

Is/was your menstrual flow heavy or light? _____ Any clots? ☐ Yes ☐ No

Have you ever had what YOU would consider to be abnormal cycles? ☐ Yes ☐ No

Explain: _____

_____

_____

When was your last period? _____ How many days did it last? _____

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? ☐ Yes ☐ No

Explain: _____

_____

Patient Name: _____

	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Bleeding Changes	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Difficulty Falling Asleep	_____	_____	_____	_____
Difficulty Staying Asleep	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Foggy Thinking	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Stress	_____	_____	_____	_____

Other: _____

_____

Patient Name: _____

What are your goals for taking Hormone Replacement Therapy?

1.
2.
3.

Doctor that we should contact for this therapy:

Name: _____ Phone: _____

Address: _____

Street City State Zip

*** Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.