

# 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you use alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you use caffeine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Do you exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: \_\_\_\_\_

<u>List Hormones Previously Taken:</u>	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.