CONFIDENTIAL HORMONE EVALUATION – FEMALE
INITIAL INTERVIEW

Today's Date: ________________

Name: _________________________________ Birthdate: ___________ Age: ______

Address: _______________________________City ____________ State: _____Zip:_______

Phone: _______________________________
Cell:______________________________
(Please indicate with an * which way you would like us to contact you)

E-Mail Address: ____

Doctor's Name:
Address:

Phone:

Height:__________________ Weight:______________________

BMI (Pharmacist will calculate)_______ (BMI = weight in kg/height in meters²)
BMI results adults over 35:

19-26.9	Recommended	30-39.9	Obese
27-29.9	Overweight	40+	Morbidly Obese

Bone Size ______ small _____ medium _____ large
Body Type: ______ apple ______ pear

Waist Circumference: ____________ Waist/Hip Ratio:_____________
Hip Circumference: ______________

What was YOUR birth weight? ________lbs Natural Deliver or C-Section: ______

How many pregnancies have you had? _______How many children? _________
Have you ever had any miscarriages? _____ No _____ Yes
Did you breastfeed your children? _____ No _____ Yes
Hysterectomy________ Ovaries removed_______ Tubal Ligation______________
If yes then date of surgery and reason why?___________________________
Do you use birth control?_______________Complications:___________________

When was your last period? ___________ How long did it last? ________________

PATIENT NAME: ____

Age when your menstrual period began: _____
Since that time have you ever had what YOU would consider to be abnormal cycles?
_____ No _____ Yes
If Yes, please explain:

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ___ No ___ Yes
If Yes, please explain symptoms:

Please list any recent surgeries (including gastric bypass)

Have you had any of the following tests performed? Check those that apply and note date of last test.

Colonoscopy	______ No	______ Yes	Date: ___________________
Mammogram	______ No	______ Yes	Date: ___________________
Bone Density	______ No	______ Yes	Date: ___________________
PAP Smear	______ No	______ Yes	Date: ___________________

Allergies: Please check all that apply

___ penicillin	___ morphine	___ dye allergies	___ pet allergies
___ codeine	___ aspirin	___ nitrate allergy	___seasonal allergies
___ sulfa drug	___ food allergies	___ no known allergies	

Other: ____

Please describe the allergic reaction:

Medical Conditions/Diseases: Please check all that apply to you.

___ heart disease (example: congestive heart failure)		___ blood clotting problems
___ high cholesterol	___ high triglycerides	___ diabetes
___ high blood pressure	___ arthritis	___ cancer (type:________)

PATIENT NAME: ____

___ depression ___ headaches/migraines ___ epilepsy
___ ulcers ___ chronic pain ___ GERD
___ hypothyroidism ___ hyperthyroidism ___ asthma
___ emphysema ___ COPD ___ glaucoma
___ psoriasis ___ Benign Prostatic Hypertrophy (BPH)
___ irritable bowel syndrome (IBS/IBD) ___ fibromyalgia
___ Other: ____

Do you have a family history of any of the following?

Uterine Cancer__________________ Family member(s) ____________________
Ovarian Cancer_________________ Family member(s) ____________________
Fibrocystic breast________________ Family member(s) ____________________
Breast Cancer___________________ Family member(s) ____________________
Heart Disease___________________Family member(s) ____________________
Osteoporosis____________________ Family member(s) ____________________
Colon Cancer ___________________ Family member(s) ____________________
Diabetes _______________________ Family member(s) ____________________
Thyroid__________________________ Family member(s) ____________________

Do you smoke? NO _______ YES _____ – how much and for how long______________
How many caffeinated beverages do you drink per day? ______________________
Portion size____
How much water do you drink per day? __________ Portion size___________________
How many alcoholic beverages do you consume in an average week?
____
How many bowel movements do you have per day? _________________
Constipation/Diarrhea____________________________
Gas/Bloating_____________________________________
Recent Weight Changes/How much/Increase or Decrease___________________
How many meals a day do you eat? ____

Please describe your
Typical breakfast:

Typical lunch:

Typical dinner:
Do you have trouble waking up in the mornings? ______ No ______ Yes
Do you take naps during the day? ______ No ______ Yes
Do you have trouble falling asleep at night? ______ No ______ Yes
Do you have trouble staying asleep? ______ No ______ Yes
Do you have sleep apnea? ______ No ______ Yes

PATIENT NAME: ____

Comments about sleep patterns: ____
____
______

Occupation:_____________________________
Do you work outside the home? _____ No _____ Yes
How many hours per week? _____________________
Do you enjoy your job? ____
Do you find your job stressful? ____
Do you find your job satisfying? ____
Do you take care of small children, elderly, or disabled adults? _____ No _____ Yes
If Yes,
explain:____
____
______
____
______
Do you have a hobby? _____ No _____ Yes
What activity relaxes you? ____
How often are you able to do this activity? ___________________________________

Is there a place in your home that you can go to relax and be alone?
____No ___Yes
Do you belong to a social or activity group outside of your family?
____ No ____ Yes
Do you have a current exercise routine?
_____No_____ Yes
If Yes, what kind of exercise and how often per week: ___________________

____
Comments

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?
Doctor _____ Self _____ Friend/Family Member _____ Other ______

What are your goals with taking BHRT?

PATIENT NAME: ____

Questions you have about BHRT

Current List Of Medications and Supplements:

Name of Medication	Dose	Times per day	Date Started

PATIENT NAME: ____

LIFE STRESS TEST

In a now-famous American study from 1967, Dr. Thomas H. Holmes and Dr. Richard H. Rahe created a do-it-yourself stress test. They examined the stress - measured the Life Changes (LCU) . that induced by experiences ranging from death of a spouse to getting a traffic ticket. By adding the LCU values of the past year, you can predict the likelihood of stress related illness or accident.

CHANCE OF ILLNESS OR ACCIDENT WITHIN 2 YEARS.

Total LCU below 150 . 35%
Total LCU between . 150 to 300 . 51%
Total LCU over 300 . 80%

_____Death of Spouse - 100
_____ Divorce . 73
_____ Marital Separation . 65
_____ Jail Term . 63
_____ Death of close family member . 63
_____ Personal injury or illness . 53
_____ Marriage . 50
_____ Fired from work . 47
_____ Marital reconciliation . 45
_____ Retirement . 45
_____ Change in family members health . 44
_____ Pregnancy . 40
_____ Sex difficulties . 39
_____ Addition to family . 39
_____ Business readjustment . 39
_____ Change in financial status . 38
_____ Death of close friend . 37
_____ Change to different line of work . 36
_____ Change in number of marital arguments . 35
_____ Mortgage or loan over $10.000 . 31
_____ Foreclosure of mortgage or loan . 30
_____ Change in work responsibilities . 29
_____ Trouble with in-laws . 29
_____ Outstanding personal achievement . 28
_____ Spouse begins or stops work . 26
_____ Starting or finishing school . 26
_____ Change in living conditions . 25
_____ Revision of personal habits . 24
_____ Trouble with boss . 23
_____ Change in work hours or conditions . 20
_____ Change in residence . 20
_____ Change in schools . 20
_____ Change in recreational habits . 19
_____ Change in social activities . 18
_____ Mortgage or loan under $10,000 . 17
_____ Change in sleeping habits . 16
_____ Change in number of family gatherings . 15
_____ Change in eating habits . 15
_____ Vacation . 13
_____ Christmas season . 12
_____ Minor violations of the law . 11

_____ **YOUR TOTAL**

This scale shows the kind of life pressure that you are facing. Depending on your coping skills or the lack thereof, this scale may predict the likelihood that you will fall victim to a stress related illness. This illness could be frequent tension headaches, acid indigestion, loss of sleep, to very serious illness like ulcers, cancer and migraines.

Daily practice of relaxation skills is very important for your wellness.
Take care of it now before serious illness erupts or an affliction becomes worse.

Please rate the following symptoms:

(0) None, (1) Mild, (2) Moderate, 3 (Severe)

PATIENT NAME: ____

Category 1: Basic Hormone Imbalance

____ Hot flashes ____Mood swings (PMS) ____Urinary incontinence ____Night sweats
____Heart palpitations ____Cystic ovaries ____Vaginal dryness ____Acne
____Foggy thinking _____Sex Drive ____Depression ____Fluid Retention
____Fibrocystic breasts ____Irritability ____Increased body/facial hair ____Bone loss
____Memory Loss _____Bladder Symptoms ____Heavy/Irregular menses _____Headaches
_____Breast Tenderness _____Arthritis ____Bone Loss _____Rapid Aging
_____Painful Intercourse _____Difficult to reach climax ___Weight Gain Hips/Waist ____Cramps

SUBTOTAL_____

Category 2: Adrenal Hormone Imbalance

____ Aches and pains ____Morning fatigue ____Elevated triglycerides ____Bone loss
____Sleep disturbances ____Depression ____Blood sugar imbalance ____Anxiety
____Infertility ____Nervousness ____Allergic conditions
____Evening fatigue ____Autoimmune illness ____Chronic illness ____Susceptibility to infections
____Sugar Cravings
____Night Sweats ____Foggy thinking ____Irritability ____Memory Lapse
____Weight gain (waist) ___No energy - afternoon ____Get a"second wind" _____Stress
____Decrease Stamina ____Low Blood Pressure ____Low Libido

SUBTOTAL_____

Category 3: Thyroid Hormone Imbalance

____Aches and pains ____Sleep disturbance ____Inability to lose weight ____Depression
____Dry/Brittle nails ____Dry skin ____Cold hands and feet ____Headaches
____Infertility ____Foggy thinking ____Menstrual irregularities ____Thinning hair
____Constipation ____Low libido ____Feeling cold all the time ____Fatigue ____Elevated cholesterol _____Heart palpitations ____Weight gain ___Dry/brittle hair

SUBTOTAL_____

TOTAL __________

Patient Homework

Keep Diet Log

Keep Symptom Log

PATIENT NAME: ____

Cabeca Form?

LABS

- Blood Sugar and A1c
- Lipids
- Cholesterol
- Iron/Blood Count
- Vitamin D
- Vitamin B12
- TSH, Free T4, Free T3

Hormone Panel

- Estradiol
- Progesterone
- Testosterone
- DHEA
- Cortisol (morning, afternoon, evening, and bedtime)

Patient Specific Labs

PATIENT NAME: ____