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 meters^2)
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:__________________

PATIENT NAME: ____

When was your last period? ___________ How long did it last? _________________
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 or augmentations)

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:

PATIENT NAME: ____

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:________)
___ 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:

PATIENT NAME: ____

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
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 toconsider Bio-Identical Hormone Replacement Therapy?
Doctor _____ Self _____ Friend/Family Member _____ Other ______

PATIENT NAME: ____

What are your goals with taking BHRT?

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.

PATIENT NAME: ____

Please rate the following symptoms:
(0) None, (1) Mild, (2) Moderate, 3 (Severe)

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	
____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 NAME: ____

Additional labs desired to help in your consult:

- Blood Sugar and A1c
- Lipids/Cholesterol or Spectracell Cardiometabolic Profile
- Iron/Blood Count (Ferritin)
- Micronutrient Test from Spectracell
- Vitamin D
- Vitamin B12
- TSH, Free T4, Free T3, TPO and Thyroid Antibodies (& Reverse T3)
- Fasting insulin
- CRP
- Homocysteine

Hormone Panel

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

PATIENT NAME: ____