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Confidential Hormone Evaluation

Medical History

GENERAL INFORMATION Date_____

Name_____Age(DOB)_____

Address:_____

Personal phone #_____Work Phone #_____

Occupation:_____ Full time☐ Part-time☐ Retired☐ Unemployed☐

Living situation: spouse☐ alone☐ partner☐ parents☐ children☐ Other:_____

Status: Married☐ Single☐ Divorced☐ Widowed☐

Pets:_____

Do you understand what Natural Hormone Replacement is?_____

What are your goals for Natural Hormone Replacement?

_____

_____

_____

Please write down any questions you have about Bio-Identical Hormone Replacement Therapy:

_____

_____

_____

_____

_____

_____

_____

MEDICAL STATUS

General Health: Excellent☐ Good☐ Fair☐ Poor☐ Height_____ Weight_____

Current diagnosis or medical conditions:

_____

_____

Drug Allergies:

_____

_____

Allergies to food:

_____

_____

Current Medications:

_____

_____

_____

Current Vitamins, supplements, or OTC products:

_____

_____

_____

Cholesterol level: _____ HDL:_____ LDL: _____ Triglycerides:_____

Have you ever had a mammogram? _____ Date: _____ Results: _____

Have you ever had a bone density scan? ____ Date: _____ Results: _____

Current healthcare providers:

_____

_____

_____

PAST MEDICAL CONDITIONS

Childhood diseases:_____

Heart trouble☐ High Blood Pressure☐ Stroke☐ Varicose veins☐ Diabetes☐

Kidney trouble☐ Epilepsy☐ Fractures☐ Arthritis☐ Colitis☐ Gallbladder☐

Asthma☐ Chronic Fatigue☐ Fibromyalgia☐ Cancer☐ Gluten Intolerance☐

HABITS

Dietary Restrictions:_____

Meal Choices: Breakfast:_____

Lunch: _____

Dinner: _____

Do you get routine physical exercise?☐ What type: _____

Do you use tobacco products?☐ How much: _____Previously: ___ How Long: ___

Do you use alcohol products?☐ How much: _____Previously: ___How Long: ____

Do you use caffeine products?☐ How much: ____

FAMILY HISTORY

Please list family members and their age, which are still living that may have important diseases such as HIGH BLOOD PRESSURE, HEART DISEASE, CANCER, OR DIABETES.

_____

_____

_____

Please list family members who died of important diseases and their age at the time of death:

_____

_____

_____

GYNECOLOGICAL HISTORY

Age of 1st period: _____ Date of last period:_____

Date of last pelvic exam: _____and pap smear: ____ Results: _____

Have you ever had an abnormal Pap?_____ Treatment: _____

Are you pregnant? _____ Current birth control method:_____

Past birth control and any related problems?_____

How many days from the start of one period to the start of the next? _____

Number of days of flow: _____ Amount of bleeding: _____

Do you have cramps: _____

Premenstrual symptoms: _____

Have you had a tubal ligation:_____ When: _____

Have you had any part or whole ovary removed? _____

Have you had a hysterectomy? _____ When? _____

Do your ovaries remain? _____

SYMPTOMS

Rate your current status for each symptom with a check mark.

	Absent	Mild	Moderate	Severe
01. Headaches				
02. Low Libido				
03. Anxiety				
04. Swollen Breast				
05. Moodiness				
06. Fuzzy Thinking				
07. Hot Flashes				
08. Night Sweats				
09. Depression				
10. Bloating				
11. Weight Gain				
12. Painful Breasts				
13. Cramps				
14. Food Cravings				
15. Insomnia				
16. Shortness of Breath				
17. Vaginal Dryness				
18. Dry Hair/Skin				
19. Mood Swings				
20. Heart Palpitations				
21. Painful Intercourse				
22. Morning Fatigue				
23. Evening Fatigue				
24. Uterine Fibroids				