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CONFIDENTIAL FEMALE HORMONE FOLLOW-UP EVALUATION

Today's Date:

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

Address:
Street City State Zip

Phone: **Email:**

Height: Weight: Desired Weight:

Allergies: Please list any allergies and describe the reaction that occurred

Drugs:
Foods:
Other:

Have you had any of the following tests since our last consultation?

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

Have symptoms stated on your initial consult improved?

☐ No, please explain

☐ Yes

What symptoms have improved?	Mild Improvement	Moderate Improvement	Major Improvement
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Are there any new unpleasant symptoms since the initial consult?

Patient Name:

Have you been compliant with the following under the recommended treatment plan?

Prescription Medications	Yes	No
Supplments	Yes	No
Dietary Changes	Yes	No

If you have answered no to the question above, are there any barriers prohibiting you from being compliant?

Have you had any changes to your medications or supplements since the initial consultation?

If you previously indicated having any of the following issues in the initial consultation, have they improved?

Stress	Yes	No	N/A	Please explain:
Sleep	Yes	No	N/A	Please explain:
Energy	Yes	No	N/A	Please explain:
Diet	Yes	No	N/A	Please explain:

Describe your diet:

How many meals per day?

How many vegetables do you eat per day?

How much fruit do you eat per day?

How much protein do you eat per day?

How much red meat do you eat per day?

How much sugar or starches per day?

How many wheat products per day?

How many snacks per day?

What is the time frame between bowel movements?
Examples: Once a day every other day or twice a day every day.

Please check any of the following gastrointestinal symptoms you are experiencing?

Diarrhea Constipation Cramps Bloating Gastric Reflux

Patient Name: _____

SYMPTOM	NONE	MILD	MODERATE	SEVERE
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Painful Intercourse				
Incontinence				
Irregular Periods				
Uterine Fibroids				
Water Retention				
Tender Breasts				
Fibrocystic Breasts				
Increased Forgetfulness				
Foggy Thinking				
Tearful				
Depressed				
Mood Swings				
Stress				
Morning Fatigue				
Evening Fatigue				
Difficulty Sleeping				
Decreased Stamina				
Anxious				
Irritable				
Nervous				
Ringing in Ears				
Fibromyalgia				
Allergies				
Headaches				
Sugar Cravings				
Dizzy Spells				
Cold Body Temperature				
Goiter				
Hoarseness				
Hair Dry or Brittle				
Nails Breaking or Brittle				
Constipation				
Slow Pulse Rate				
Rapid Heartbeat				
Heart Palpitations				
Infertility Concerns				
Acne				
Increased Facial/Body Hair				
Scalp Hair Loss				
Weight Gain-Hips				
Weight Gain-Waist				
High Cholesterol				
Elevated Triglycerides				
Decreased Libido				
Decreased Muscle Mass				
Decreased Flexibility				
Burned Out Feeling				
Increased Joint Pain				
Neck or Back Pain				
IBS				
Thinning Skin				
Rapid Aging				
Aches & Pains				
Bone Loss				

Patient Name:

Have you met any of your goals while taking your Hormone Replacement Therapy?

1.
2.
3.
4.
5.
6.

What questions have come up since the onset of your therapy?

Discuss the impact of the current therapy you have experienced from a quality-of-life perspective.

Discuss symptoms that have improved or areas not responding to current therapy.

Discuss any potential barriers preventing the patient form following current course of treatment.

Discuss any new developments or symptoms that need to be addressed.

*****THE FOLLOWING WILL BE FILLED OUT BY YOUR HEALTHCARE CONSULTANT*****

Adjust, create new, or maintain current therapy on findings in the follow-up session if applicable.

Change in therapy recommendation sent to your physician to review if applicable.

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