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CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date:

| Name: | | | | Birthdate: | Age: | |
|----------------------------|------------------------------|-------------------|--|-----------------|-------|-----|
| Address: | Street | | | City | State | Zip |
| Phone: | | | Email: | | | |
| Height: | Weigh | nt: | Desired Weight: | | | |
| Allergies: Please list a | □Yes □Yes □Yes □Yes | □No □No □No | If yes, describe: If yes, describe: If yes, describe: If yes, describe: describe the reactio | n 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 Strength

Date Started

How Often per day

Patient Name:

| | | | Fatient Na | ine. | | |
|---|---|-----------------|--|------------------------|--------------------|----|
| List Hormones F Na | Previous me | ily Taken: | Date Started | Date Stopped | Reason | |
| | | | | | | |
| Have you ever u If you experienc | | • | s (birth control)? □Y se describe: | es □No | | |
| How many preg | nancies | have you had? | How many childre | en? Any Interrupte | d pregnancies? Yes | No |
| • | tubal lig | - | \Box No If yes, date of \Box No If yes, date of | | | |
| Do you have a fa | • | | in? □Yes □ No cers or osteoporosis? | Please list the family | / member(s): | |
| Have you had a | ny of the | e following tes | ts performed? | | | |
| Mammography | □Yes | □No | Date: | Outcome: | | |
| PAP Smear | □Yes | □No | Date: | Outcome: | | |
| Bone Density | □Yes | □No | Date: | Outcome: | | |
| What age did yo | our perio | od start? | How many days i | s/was your cycle (Exa | ample: 28): | |
| Is/was your me | Is/was your menstrual flow heavy or light? Any clots? Yes No | | | | | |
| Have you ever had what YOU would consider to be abnormal cycles? \Box Yes \Box No | | | | | | |
| Explain: | | | | | | |
| When was your | • | | | | | |
| How many days | | | | () | | |
| - | you eve | r suffered from | Premenstrual Syndro | ome (PMS) symptom | s? ∟Yes ∟ No | |
| Explain: | : | | | | | |
| Describe your d | | 2 | | | | |
| How many mea How many vege | - | - | Sveh | | | |
| | | | uay: | | | |
| 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? | | | | | | |
| | | | | | | |

Patient Name:

| int FishesIIIIIINight SwetsIIIIIIPainful IntercourseIIIIIIPainful IntercourseIIIIIIIrregular PeriodsIIIIIIIUterine FibrodisIII <td< th=""><th>SYMPTOM</th><th>NONE</th><th>MILD</th><th>MODERATE</th><th>SEVERE</th></td<> | SYMPTOM | NONE | MILD | MODERATE | SEVERE |
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| Painful IntercourseImage in ProtosImage in P | Night Sweats | | | | |
| Painful IntercourseImage in ProtosImage in P | Vaginal Dryness | | | | |
| IncontenceIIIIIIregular PeriodsIIIIIIWater RetentionIIIIIIWater RetentionIIIIIIFibrorystic BreastsIIIIIIFibrorystic BreastsIIIIIIFibrorystic BreastsIIIIIIFogy ThinkingIIIIIITearfulIIIIIIIDepressedIIIIIIIMood SwingsII <t< th=""><th></th><th></th><th></th><th></th><th></th></t<> | | | | | |
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| Thinning Skin I I I Rapid Aging I I I I Aches & Pains I I I I | Neck or Back Pain | | | | |
| Rapid Aging□□□Aches & Pains□□□ | IBS | | | | |
| Aches & Pains | Thinning Skin | | | | |
| | | | | | |
| Bone Loss | Aches & Pains | | | | |
| | Bone Loss | | | | |

Patient Name: .

| Do you have work related stress? 🗌 Yes 🛛 No |
|---|
| If yes, explain: |
| Do you have financial related stress? 🗌 Yes 🛛 No |
| Do you have relationship related stress? 🗌 Yes 🛛 No |
| Have you had any stress full event or traumatic event in the past? $\ \square$ Yes $\ \square$ No |
| Have had any illnesses related to any type of infection in the past? \square Yes \square No |
| Have you had any type of surgery in the past? \Box Yes \Box No |
| Do you have difficulty sleeping? 🗆 Yes 🛛 No |
| If yes, explain? |
| What time do you typically go to bed? |
| What time do you typically fall asleep? |
| Do you work any type of shift work? 🗆 Yes 🛛 No |
| If yes, explain? |
| Have you dieted in the past? \Box Yes \Box No |
| How often do you diet? |
| When was the last time you dieted? |
| Have you been diagnosed with diabetes? 🗌 Yes 🛛 No |
| Are you insulin resistant? 🗌 Yes 🛛 No 🗌 Do not know |
| Do you have high cholesterol? 🗌 Yes 🛛 No |
| Do you have high triglycerides? 🗌 Yes 🗌 No |
| Do you have high blood pressure? 🗆 Yes 🛛 No |
| What are your goals for taking Hormone Replacement Therapy? |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| Doctor that we should contact for this therapy: |
| Name: Phone: |
| Address: |
| Street City State Zip |
| |

*** Please email a copy to cwells@cptinc.org or fax to 1-866-684-6337. Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.