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CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date:

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

Address:
Street City State Zip

Phone: **Email:**

Height: Weight: Desired Weight:

How Often and how much?

Do you use tobacco? Yes No If yes, describe:

Do you use alcohol? Yes No If yes, describe:

Do you use caffeine? Yes No If yes, describe:

Do you exercise? Yes No If yes, describe:

Allergies: Please list any allergies and describe the reaction 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:

List Hormones Previously Taken:

Name	Date Started	Date Stopped	Reason

Have you ever used oral contraceptives (birth control)? Yes No

If you experienced any problems, please describe:

How many pregnancies have you had? How many children? Any Interrupted pregnancies? Yes No

If yes, please explain:

Have you had a tubal ligation? Yes No If yes, date of surgery:

Have you had a hysterectomy? Yes No If yes, date of surgery:

Reason:

Do your ovaries remain? Yes No

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

Have you had any of the following tests performed?

Mammography Yes No Date: Outcome:

PAP Smear Yes No Date: Outcome:

Bone Density Yes No Date: Outcome:

What age did your period start? How many days is/was your cycle (Example: 28):

Is/was your menstrual flow heavy or light? Any clots? Yes No

Have you ever had what YOU would consider to be abnormal cycles? Yes No

Explain:

When was your last period?

How many days did it last?

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? Yes No

Explain:

Describe your diet:

How many meals per day?

How many vegetables do you eat per week?

How much fruit do you eat per week?

How much protein do you eat per week?

How much red meat do you eat per week?

How much sugar or starches per week?

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:

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? Yes No

Have had any illnesses related to any type of infection in the past? Yes No

Have you had any type of surgery in the past? Yes 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? Yes 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.