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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:

			Patient	. Name:		
List Hormones	Previous	sly Taken:				
Na	ime		Date Started	Date Stopped	Reason	
Have you ever u	used ora	al contraceptive	es (birth control)?	□Yes □No		
If you experient	ced any	problems, plea	se describe:			
How many preg	;nancies	have you had?	P How many chi	ldren? Any Interrupte	d pregnancies? Yes	No
If yes, please ex	plain:					
Have you had a	tubal li	gation? □Yes	\square No If yes, dat	e of surgery:		
Have you had a Reason:	hystere	ectomy? □Yes	\Box No If yes, date	e of surgery:		
Neuson.	_					
Do you baya a fa	•		in? 🗆 Yes 🗆 No	sis? Please list the family	(mombor(s))	
Do you have a la	111119 1115		icers of osteoporo	sis: Flease list the failing	member(s).	
	.		6 10			
Have you had a		-				
Mammography			Date:	Outcome:		
PAP Smear		□No	Date:	Outcome:		
	□Yes		Date:	Outcome:		
What age did y	•			ys is/was your cycle (Exa	ample: 28):	
Is/was your me		-	-	Any clots? □Yes □No		
	nad wha	it YOU would co	onsider to be abno	ormal cycles? \Box Yes \Box No	0	
Explain:						
When was your						
How many days			- Drama an atmosf Com			
-	you eve	er suffered from	n Premenstrual Syl	ndrome (PMS) symptom	S? ∟Yes ∟ NO	
Explain:	liati					
Describe your o						
How many mea	•	-	wook?			
How many vege						
How much fruit	-	-				
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How much red How much suga						
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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.