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CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date: Click or tap here to enter text.

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: Click or tap here to enter text.
Do you use alcohol? ☐Yes ☐No If yes, describe: Click or tap here to enter text.
Do you use caffeine? ☐Yes ☐No If yes, describe: Click or tap here to enter text.
Do you exercise? ☐Yes ☐No If yes, describe: Click or tap here to enter text.

Allergies: Please list any allergies and describe the reaction that occurred
Drugs: Click or tap here to enter text.
Foods: Click or tap here to enter text.
Other: Click or tap here to enter text.

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements): Click or tap here to enter text.
Click or tap here to enter text.
Click or tap here to enter text.
Click or tap here to enter text.
Click or tap here to enter text.
Click or tap here to enter text.

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). Click or tap here to enter text.
Click or tap here to enter text.
Click or tap here to enter text.
Click or tap here to enter text.

Current Prescription Medications (including hormones):

Medication Name	Strength	Date Started	How Often per day
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			

Patient Name: Click or tap here to enter text.

List Hormones Previously Taken:

Name	Date Started	Date Stopped	Reason
Click or tap here to enter text.			
Click or tap here to enter text.			
Click or tap here to enter text.			

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

If you experienced any problems, please describe: Click or tap here to enter text.

Click or tap here to enter text.

How many pregnancies have you had? Click or tap here to enter text. How many children?

Any Interrupted pregnancies? ☐Yes ☐No

If yes, please explain: Click or tap here to enter text.

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: Click or tap here to enter text. Do your ovaries remain? ☐Yes ☐No

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

Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

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? Click or tap here to enter text. Any clots? ☐Yes ☐No

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

Explain: Click or tap here to enter text.

Click or tap here to enter text.

Click or tap here to enter text.

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: Click or tap here to enter text.

Click or tap here to enter text.

Describe your diet: Click or tap here to enter text.

Click or tap here to enter text.

How many meals per day? Click or tap here to enter text.

How many vegetables do you eat per week? Click or tap here to enter text.

How much fruit do you eat per week? Click or tap here to enter text.

How much protein do you eat per week? Click or tap here to enter text.

How much red meat do you eat per week? Click or tap here to enter text.

How much sugar or starches per week? Click or tap here to enter text.

Patient Name: Click or tap here to enter text.

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	☐	☐	☐	☐

Do you have work related stress? ☐ Yes ☐ No

If yes, explain: Click or tap here to enter text.

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? Click or tap here to enter text.

What time do you typically go to bed? Click or tap here to enter text.

What time do you typically fall asleep? Click or tap here to enter text.

Do you work any type of shift work? ☐ Yes ☐ No

If yes, explain? Click or tap here to enter text.

Have you dieted in the past? ☐ Yes ☐ No

How often do you diet? Click or tap here to enter text.

When was the last time you dieted? Click or tap here to enter text.

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. Click or tap here to enter text.
2. Click or tap here to enter text.
3. Click or tap here to enter text.
4. Click or tap here to enter text.
5. Click or tap here to enter text.
6. Click or tap here to enter text.

Doctor that we should contact for this therapy:

Name: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text. Click or tap here to enter text.
Street City State Zip

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