CONFIDENTIAL HORMONE EVALUATION
MEDICAL HISTORY

Today's Date ___________________

Name ____ DOB ____________________ Age______________

Address ____

City: ____ State: __________________ Zip: __________________

Phone: ____ Email:____

Home#: (   ) _______________Work#: (   ) _______________Mobile#: (   )_______________

Height _________________ Weight____________

How did you hear about Natural Hormone Replacement Therapy: Magazine Ad__ Internet __ Patient__
Course/Seminar__ Physician Health __ Practitioner __ Book/Article __Other__________________________

Occupation: ____________________________Full time __Part time __Retired __Unemployed __Other__

Living Situation (with): Spouse__ self __ Partner __ Friend(s)__Parents __Children __ Other __

Status: Married__ Single__ Divorced__ Widowed__

Pets:____

Dietary Restrictions:____

Meal Choices: Breakfast:____

Lunch:____

Dinner:____

Do you routinely exercise?:___________ If so, how frequent and what type?______________________________________

Do you currently use tobacco products?:______ How much?:______ Previously?:_______For how long?:____________

Do you currently use alcohol products?: ______How much?:_______________Previously?:_____For how long?:_______

Do you use any caffeine products?:____________________How much?:____

Doctor's Name: Address: Phone:

____

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Allergies: Please check all that apply:

____Penicillin ____Morphine ____Dye allergies ____Pet allergies

____Codeine ____Aspirin ____Nitrate allergy ____Seasonal (pollen) allergies

____Sulfa drug ____Food allergies ____No known allergies

Other:____

Please describe the allergic reaction you experienced and when it occurred?

____

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Please check all products that you use occasionally or regularly.

____Pain Reliever

____Aspirin

____Acetaminophen

____Ibuprofen

____Naproxen

____Ketoprofen

____ Cough Suppressant

____Antihistamine products

____Decongestant products

____ Combination Products (cough+cold reliever)

____ Sleep Aids

____Antidiarrheals

____Laxatives/Stool Softeners

____Diet aids/Weight Loss products

____Antacids

____Acid Blockers

Other (please list below):

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Names of ALL prescription medications (including hormones) , taken in last 6 months:

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Medical Conditions/Diseases:

____Heart Disease (example: Congestive Heart Failure)

____High blood pressure (example: Hypertension)

____Ulcers (stomach, esophagus)

____Hormonal Related Issues

____Blood Clotting Problems

____Arthritis or joint problems

____Epilepsy

____Eye Disease (glaucoma, etc.)

____High Cholesterol or lipids (example: Hyperlipidemia)

____Cancer

____Thyroid Disease

____Lung Condition (examples: asthma, emphysema, COPD)

____Diabetes

____Depression

____Headaches/Migraines

Other (please list below):

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Have you ever had your cholesterol level checked?:_______Date:___/___/___Results:_________________________________

Have you ever had a bone density scan: ____Date:___/___/___Results:____

Do you have a family history of any of the following?

____Uterine Cancer
____Ovarian Cancer
____Breast Cancer
____Fibrocystic Breast
____Heart Disease
____Osteoporosis
____Thyroid Disorder

How many Pregnancies have you had? ____ How many Children do you have? __________
Any interrupted pregnancies? ____yes ____no
Have you had a hysterectomy? ____yes ____no If yes, date of Surgery? ______________
Ovaries Removed? ____yes ____no If yes, date of Surgery? ______________
Have you had tubal ligation? ____yes ____no If yes, date of Surgery? ______________
Have you had a Mammography? ____yes ____no When was the last test? ______________
What were the results?______________
Have you had a PAP Smear Test performed? ____yes ____no When was the last test?______________
What were the results?______________

Since your periods began have you ever had what YOU would consider to be abnormal cycles?
____yes ____no If yes, please describe:
____
____

When was your last period? and how many days did it last? ____
Do you have, or ever had Premenstrual Syndrome (PMS) ?, if yes explain symptoms:
____
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What is your greatest need or concern?
____
____

Please review the following symptoms and grade them if they are present:

Fibrocystic Breast	____NA	____Mild	____Moderate	____Severe
Heavy/Irregular Menses	____NA	____Mild	____Moderate	____Severe
Weight Gain	____NA	____Mild	____Moderate	____Severe
Hot Flashes	____NA	____Mild	____Moderate	____Severe
Dry Skin/Hair	____NA	____Mild	____Moderate	____Severe
Anxiety	____NA	____Mild	____Moderate	____Severe
Depression	____NA	____Mild	____Moderate	____Severe
Night Sweats	____NA	____Mild	____Moderate	____Severe
Vaginal Dryness	____NA	____Mild	____Moderate	____Severe
Headaches	____NA	____Mild	____Moderate	____Severe
Irritability	____NA	____Mild	____Moderate	____Severe
Mood Swings	____NA	____Mild	____Moderate	____Severe
Breast Tenderness	____NA	____Mild	____Moderate	____Severe

Symptom	NA	Mild	Moderate	Severe
Sleep Disturbances/Insomnia	____NA	____Mild	____Moderate	____Severe
Cramps	____NA	____Mild	____Moderate	____Severe
Fluid Retention	____NA	____Mild	____Moderate	____Severe
Breakthrough Bleeding	____NA	____Mild	____Moderate	____Severe
Fatigue	____NA	____Mild	____Moderate	____Severe
Loss of Memory	____NA	____Mild	____Moderate	____Severe
Bladder Symptoms	____NA	____Mild	____Moderate	____Severe
Arthritis	____NA	____Mild	____Moderate	____Severe
Harder to Reach Climax	____NA	____Mild	____Moderate	____Severe
Decreased Sex Drive	____NA	____Mild	____Moderate	____Severe
Hair Loss	____NA	____Mild	____Moderate	____Severe

What are your goals with taking BHRT? What is your greatest need or concern?

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Please write down any questions you have about Bio-Identical Hormone Replacement Therapy:

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