# CONFIDENTIAL HORMONE EVALUATION

## MEDICAL HISTORY

**Today's Date:** _____

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

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **E-Mail Address:** _____

**Height:** _____ **Weight:** _____ **Any loss in past year? Y ___ N ___ BMI:** _____

How often and how much?

Do you use tobacco? ___Yes ___No _____

Do you use alcohol? ___Yes ___No _____

Do you use caffeine? ___Yes ___No _____

**Doctor's Name:** **Address:** **Phone:**

_____

_____

_____

_____

**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?

_____

_____

_____

_____

**Over-the-counter (OTC) issues:**

Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever
___ Aspirin
___ Acetaminophen (example: Tylenol)
___ Ibuprofen (example: Motrin IB)
___ Naproxen (example: Aleve)
___ Ketoprofen (example: Orudis KT)
___ Cough suppressant (example: Robitussin DM)
___ Antihistamine product (example: Chlor-Trimeton)
___ Decongestant product (example: Sudafed)
___ Combination product (cough+cold reliever)(example: Triaminic DM)
___ Sleep aids (examples: Excedrin PM, Unisom, Sominex, Nytol)
___ Antidiarrheals (examples: Imodium, Pepto Bismol, Kaopectate)
___ Laxatives/stool softeners (examples: Doxidan, Correctol, etc.)
___ Diet aids/weight loss products (example: Dexatrim)
___ Antacids (examples: Maalox, Mylanta)
___ Acid blockers (examples: Tagamet HB, Pepcid C, Zantac 75)
___ Other (please list)
_____

**PATIENT NAME:** _____

_____ **Nutritional/Natural Supplements: Please identify and list the products you are using:**

___ vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
___ minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
___ herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
___ enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
___ nutrition/protein supplements (examples: shark cartilage, protein powders, amino acids, fish oils, etc.)
___ others (glucosamine, etc.)

**Medical Conditions/Diseases:** Please check all that apply to you.

| | | | |
|---|---|---|---|
| ___ | Heart disease (example: Congestive Heart Failure) | ___ | Blood Clotting Problems |
| ___ | High cholesterol or lipids (examples: Hyperlipidemia) | ___ | Diabetes |
| ___ | High blood pressure (example: Hypertension) | ___ | Arthritis or joint problems |
| ___ | Cancer | ___ | Depression |
| ___ | Ulcers (stomach, esophagus) | ___ | Epilepsy |
| ___ | Thyroid disease | ___ | Headaches/migraines |
| ___ | Hormonal Related Issues | ___ | Eye Disease (glaucoma, etc.) |
| ___ | Lung condition (example: asthma, emphysema, COPD | ___ | Other: Please list: _____ |

_____
_____

**Current Prescription Medications:**

| Medication Name | Strength | Date Started | How often per day |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **List Hormones previously taken:** | Date Started | Date Stopped | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever used oral contraceptives? ____ No ____ Yes
Any problems? ____ No ____ Yes
If YES, describe any problem(s).

_____
_____

**How many pregnancies have you had? _____** **How many children? _____**

| | | |
|---|---|---|
| Any interrupted pregnancies? (miscarriage or abortion) | ___ No | ___ Yes |
| Have you had a hysterectomy? | ___ No | ___ Yes (Date of Surgery)_____ |
| Ovaries removed? | ___ No | ___ Yes |
| Have you had a tubal ligation? | ___ No | ___ Yes (Date) |

**PATIENT NAME:** _____

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

| | | | |
|---|---|---|---|
| Uterine Cancer | _____ | Family member (s) | _____ |
| Ovarian Cancer | _____ | Family member (s) | _____ |
| Fibrocystic Breast | _____ | Family member (s) | _____ |
| Breast Cancer | _____ | Family member (s) | _____ |
| Heart Disease | _____ | Family member (s) | _____ |
| Osteoporosis | _____ | Family member (s) | _____ |

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**Have you had any of the following tests performed? Check those that apply and note date of last test.**

| | | | |
|---|---|---|---|
| Mammography | ___ No | ___ Yes | Date: _____ |
| PAP Smear | ___ No | ___ Yes | Date: _____ |

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?

___ No ___ Yes Date: _____

If YES, please explain (such as age when this occurred, symptoms….):

_____

_____

_____

_____

_____

When was your last period? _____Regular: _____

Irregular: _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ___ No ___Yes

If YES, explain symptoms:

_____

_____

_____

_____

**How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?**

Doctor ___ Self ___ Friend/Family Member ___ Other ___

**What are your goals with taking BHRT?**

_____

_____

_____

_____

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

_____

_____

_____

_____

**Patient Name: _____**

**HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET**

**----These should be current symptoms.----**

| | ABSENT | MILD | MODERATE | SEVERE |
|---|---|---|---|---|
| Fibrocystic Breast | _____ | _____ | _____ | _____ |
| Weight Gain | _____ | _____ | _____ | _____ |
| Heavy/Irregular menses | _____ | _____ | _____ | _____ |
| Hot Flashes | _____ | _____ | _____ | _____ |
| Dry Skin/Hair | _____ | _____ | _____ | _____ |
| Anxiety | _____ | _____ | _____ | _____ |
| Depression | _____ | _____ | _____ | _____ |
| Night Sweats | _____ | _____ | _____ | _____ |
| Vaginal Dryness | _____ | _____ | _____ | _____ |
| Headaches | _____ | _____ | _____ | _____ |
| Irritability | _____ | _____ | _____ | _____ |
| Mood Swings | _____ | _____ | _____ | _____ |
| Breast Tenderness | _____ | _____ | _____ | _____ |
| Sleep Disturbances/Insomnia | _____ | _____ | _____ | _____ |
| Cramps | _____ | _____ | _____ | _____ |
| Fluid Retention | _____ | _____ | _____ | _____ |
| Breakthrough Bleeding | _____ | _____ | _____ | _____ |
| Fatigue | _____ | _____ | _____ | _____ |
| Loss of Memory | _____ | _____ | _____ | _____ |
| Bladder Symptoms | _____ | _____ | _____ | _____ |
| Arthritis | _____ | _____ | _____ | _____ |
| Harder to Reach Climax | _____ | _____ | _____ | _____ |
| Decreased Sex Drive | _____ | _____ | _____ | _____ |
| Hair Loss | _____ | _____ | _____ | _____ |
| Aches/Pains | _____ | _____ | _____ | _____ |
| Allergies | _____ | _____ | _____ | _____ |
| Bone loss | _____ | _____ | _____ | _____ |
| Cold body temp | _____ | _____ | _____ | _____ |
| Oily all over | _____ | _____ | _____ | _____ |
| Cystic ovaries | _____ | _____ | _____ | _____ |
| Fibroids | _____ | _____ | _____ | _____ |
| Increased Triglycerides | _____ | _____ | _____ | _____ |
| Heart palpitations | _____ | _____ | _____ | _____ |
| Fibromyalgia | _____ | _____ | _____ | _____ |
| Sugar Cravings | _____ | _____ | _____ | _____ |
| Acne | _____ | _____ | _____ | _____ |
| Indigestion/bloating | _____ | _____ | _____ | _____ |

**Have you EVER had a blood clot?** **Yes_____** **No_____**

**Patient Name:**_____