Hormone Evaluation

Date: _______________

Name: ____________________________________ Birth date: ______________

Gender: Female ____ Male ___ Height: __________ Weight: __________

Medical History:

Current Providers:

Doctor's Name: Address: Phone:

____

____

____

____

Allergies: ____

Medical Conditions/Diseases: Check all that apply

___ Heart Disease
___ High cholesterol/lipids
___ High blood pressure
___ Cancer
___ Ulcers
___ Thyroid Disease
___ Hormonal/Menstrual issues
___ Lung Conditions
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression/Anxiety
___ Epilepsy
___ Headaches/Migraines
___ Eye Disease
___ Other: ________________

Have you undergone any surgeries? Please list __________________________________

For Females:

How many pregnancies have you had? _______ How many children? ______

Any interrupted pregnancies? _______

Have you undergone hysterectomy or removal of ovaries? If yes, what was the reason for surgery and date? ____

When was your last menstrual period? _________ How many days did it last? _______

Do you have Premenstrual Syndrome (PMS)? If yes, please list symptoms ____________

____

Do you ever have irregular cycles or abnormal cycles? ___________________________

Do you do Self Breast Exams? _______

Have you had the following screening tests?
Mammogram: ________ Date of last test: _______
Pap Smear: ___________ Date of last test: _______

For Males:
How many children do you have? _______

Have you undergone vasectomy? _______

Do you have any trouble with erectile dysfunction? _______ Low libido? _______

Do you do regular testicular exams? _______

Have you had the following screening tests?
Prostate Exam: ________ Date of last test: _______
PSA : ___________ Date of last test: _______

Family History:

Do you have any of the following in your family?

	Yes/No	Family Member(s)
Uterine Cancer	_______	_____________________
Ovarian Cancer	_______	_____________________
Breast Cancer	_______	_____________________
Prostate Cancer	_______	_____________________
Heart Disease	_______	_____________________
Osteoporosis	_______	_____________________
Diabetes	_______	_____________________
Stroke	_______	_____________________
Clotting disorder	_______	_____________________

Social History:

Tobacco Use:	___ yes ___ no	Amount per day: _______	Past Use: _______
Alcohol Use:	___ yes ___ no	Amount per day: _______	Past Use: _______
Drug Use:	___ yes ___ no	Type used: ____________	Past Use: _______

Medication History:

Please list any over the counter (OTC) products used regularly or occasionally:

____

____

Please list any supplements or vitamins used regularly or occasionally:

____

____

Current Prescription Medications:

Name:	Strength:	Times per day:	Date started:

Hormones previously taken:	Date started:	Date Ended:	Reason for stopping:

Have you ever used oral contraceptives? ________
Did you have any problems with these? _________
If yes, please describe any problems: ____

How did you arrive at the decision to start Bio-Identical Hormone replacement?

____

What are your goals with taking Bio-Identical Hormone replacement therapy?

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Please list any questions or concerns you have regarding Bio-Identical replacement:

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Current Medical Concerns and Review of Systems:

Please check the category that best applies to you:

	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 Trouble/Insomnia	_______	_______	_______	_______
Cramps	_______	_______	_______	_______
Fluid Retention	_______	_______	_______	_______
Vaginal Spotting	_______	_______	_______	_______
Fatigue	_______	_______	_______	_______
Loss of Memory	_______	_______	_______	_______
Bladder Symptoms	_______	_______	_______	_______
Arthritis	_______	_______	_______	_______
Difficulty Reaching Climax	_______	_______	_______	_______
Decreased Sex Drive	_______	_______	_______	_______
Hair Loss	_______	_______	_______	_______
Constipation	_______	_______	_______	_______

Please list any other problems you are having today: ______________________________

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