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Female Hormone Evaluation Form Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

Gender: Male Female Height: _____ Weight: _____

Do you use tobacco? Yes No
Do you use alcohol? Yes No
Do you use caffeine? Yes No
How often and how much?

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

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 powers, 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Bone Size _____ Small _____ Medium _____ Large _____

Body Type: Androgenic Estrogenic

Have you ever used oral contraceptives? No Yes
Any problems? No Yes

If YES, describe any problem(s).

PATIENT NAME: _____

How many pregnancies have you had? _____

How many children? _____

Any interrupted pregnancies? No

Yes

Have you had a hysterectomy?
Ovaries removed? No

Yes (Date of Surgery) _____
 Yes

Have you had a tubal ligation? No

Yes (Date) _____

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

Uterine Cancer _____
Ovarian Cancer _____
Fibrocystic breast _____
Breast Cancer _____
Heart Disease _____
Osteoporosis _____

Family member(s) _____
Family member(s) _____
Family member(s) _____
Family member(s) _____
Family member(s) _____
Family member(s) _____

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? _____

How many days did it last? _____

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

If YES, explain symptoms:

PATIENT NAME: _____

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

	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	_____	_____	_____	_____

Patient Name: _____