

CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Height: _____ Weight: _____ Desired Weight: _____

Occupation: _____ Hobbies: _____

How often and how much?

Do you use tobacco/nicotine? Yes No _____
Do you use alcohol? Yes No _____
Do you use caffeine? Yes No _____
Do you exercise? Yes No _____

How long have you exercised? (months/years) _____

Type of exercise preferred. _____

If yes, please elaborate (dates/frequency):

Have you ever had a panic attack? Yes No _____
Do you have OCD? Yes No _____
Any diagnosis of mental illness? Yes No _____
Every had a head injury/concussion? Yes No _____

How frequent are your bowel movements? _____

Typical # of hours of sleep per night: _____ Normal bedtime: _____

Uninterrupted? Yes No Time and reason for interruption: _____

Do you wake rested or tired (even when getting 7-8 hours of sleep)? _____

Are you or have you ever been a night shift worker? Yes No

If yes, please describe when and for how long: _____

My diet is:

_____ Super healthy
_____ Mostly healthy
_____ Needs work
_____ Terrible

What would you like to change about your current dietary choices? _____

Patient Name: _____

Allergies: Please list any allergies and describe the reaction that occurred.

Drugs: _____

Foods: _____

Other: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements): _____

CBD/THC Use: Please list any products used and frequency: _____

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.).

Have you ever tested positive for Epstein-Barr virus? Yes No

If yes, please elaborate (dates/current status): _____

Current Prescription Medications (including hormones):

Medication Name and Strength	Date Started	How Often per Day	Medical Condition Being Treated
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<u>List Hormones Previously Taken:</u>	Date Started	Date Stopped	Reason
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Have you ever used oral contraceptives (birth control)? Yes No

If you experienced any problems, please describe: _____

Patient Name: _____

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

Any interrupted pregnancies? Yes No

If yes, please explain: _____

If you have been pregnant, how did you feel while pregnant? Please explain (ex: great, horrible, to be expected) _____

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 for hysterectomy/diagnosis: _____

Do your ovaries remain? Yes No

Have you had an endometrial ablation? Yes No If yes, date of surgery: _____

Date of COVID infection/vaccine: _____

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

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? _____ Any clots? Yes No

At what age (if known) did your mother, maternal aunts, sisters go through menopause?

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

Explain: _____

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: _____

Patient Name: _____

Hot Flashes

of times/day AM _____ Mid-day _____ PM _____ ALL DAY _____

Intensity of each time of day (label each time of day as mild, moderate, or severe):

_____ _____ _____ _____
Absent Mild Moderate Severe

Night Sweats

_____ _____ _____ _____

Describe

Vaginal Dryness

_____ _____ _____ _____

Describe

Incontinence

_____ _____ _____ _____

Describe

Bleeding Changes

_____ _____ _____ _____

Describe

Fibrocystic Breast

_____ _____ _____ _____

Describe

Weight Gain

_____ _____ _____ _____

Describe

Fluid Retention

_____ _____ _____ _____

Describe

Dry Skin/Hair

_____ _____ _____ _____

Describe

Hair Loss

_____ _____ _____ _____

Describe

Anxiety

_____ _____ _____ _____

Describe

Depression

_____ _____ _____ _____

Describe

Mood Swings

_____ _____ _____ _____

Describe

Patient Name: _____

	Absent	Mild	Moderate	Severe
Irritability	_____	_____	_____	_____
Describe	_____			
Headaches	_____	_____	_____	_____
Describe	_____			
Breast Tenderness	_____	_____	_____	_____
Describe	_____			
Cramps	_____	_____	_____	_____
Describe	_____			
Difficulty Falling Asleep	_____	_____	_____	_____
Describe	_____			
Difficulty Staying Asleep	_____	_____	_____	_____
Describe	_____			
Fatigue	_____	_____	_____	_____
Describe	_____			
Loss of Memory	_____	_____	_____	_____
Describe	_____			
Foggy Thinking	_____	_____	_____	_____
Describe	_____			
Acne	_____	_____	_____	_____
Describe	_____			
Arthritis	_____	_____	_____	_____
Describe	_____			
Decreased Sex Drive	_____	_____	_____	_____
Describe	_____			
Harder to Reach Climax	_____	_____	_____	_____
Describe	_____			
Stress	_____	_____	_____	_____
Describe	_____			
Sugar Cravings	_____	_____	_____	_____
Describe	_____			

Patient Name: _____

	Absent	Mild	Moderate	Severe
Excess Facial/Body Hair	_____	_____	_____	_____
Describe	_____			

Other Symptoms:

What are your goals for taking Hormone Replacement Therapy?

1. _____
2. _____
3. _____

When in your lifetime did you feel the best? (please explain with details)

Doctor who we should contact for this therapy:

Name: _____ Phone: _____

Address: _____
Street City State Zip

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