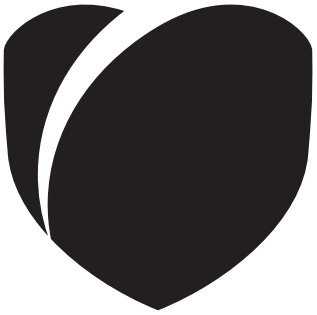
Confidential Women's Health Hormone Evaluation

RETURN UPON COMPLETION TO:



SHRIVERS
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Confidential Female Hormone Evaluation

Today's Date: _____

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

Address: _____

Phone: _____ **Email:**_____

Height:_____ **Weight:** _____ **Desired Weight:** _____ **Married** ❑ **Divorced** ❑ **Single** ❑

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

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

Drugs: _____
Foods: _____
Other: _____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc.)

_____
_____
_____

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

_____
_____
_____
_____
_____

Current Prescription Medications (including hormones):

Medication Name and Strength	*Date Started*	*How Often Per Day*

Patient Name: _____

Have you ever used oral contraceptives (birth control)? ❑Yes ❑No

If Yes, What & When: _____

Have you ever used an IUD or B.C. shot? ❑Yes ❑No

If Yes, What & When: _____

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

Any Interrupted pregnancies? ❑Yes ❑No

If Yes, please explain: _____

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: _____ Do your ovaries remain? ❑Yes ❑No

List Hormones Previously Taken: Date Started Date Stopped Reason

_____

_____

_____

_____

If you experienced any problems, please describe: _____

_____

Do you have any 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

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: _____

	Absent	Mild	Moderate	Severe
Hot Flashes	❑	❑	❑	❑
Night Sweats	❑	❑	❑	❑
Vaginal Dryness	❑	❑	❑	❑
Incontinence	❑	❑	❑	❑
Bleeding Changes	❑	❑	❑	❑
Fibrocystic Breast	❑	❑	❑	❑
Weight Gain	❑	❑	❑	❑
Fluid Retention	❑	❑	❑	❑
Dry Skin/Hair	❑	❑	❑	❑
Hair Loss	❑	❑	❑	❑
Anxiety	❑	❑	❑	❑
Depression	❑	❑	❑	❑
Mood Swings	❑	❑	❑	❑
Irritability	❑	❑	❑	❑
Headaches	❑	❑	❑	❑
Breast Tenderness	❑	❑	❑	❑
Cramps	❑	❑	❑	❑
Difficulty Falling Asleep	❑	❑	❑	❑
Difficulty Staying Asleep	❑	❑	❑	❑
Fatigue	❑	❑	❑	❑
Loss of Memory	❑	❑	❑	❑
Foggy Thinking	❑	❑	❑	❑
Acne	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑
Decreased Sex Drive	❑	❑	❑	❑
Harder to Reach Climax	❑	❑	❑	❑
Stress	❑	❑	❑	❑

Other: _____

_____

Patient Name: _____

What are your goals for taking Hormone Replacement Therapy?

1.

2.

3.

Doctor that we should contact for this therapy:

Name: _____ **Phone:**_____

Address: _____

Street *City* *State* *Zip*