CONFIDENTIAL HORMONE EVALUATION - FEMALE

Today's Date: _______________

Name: _______________________________ Birthdate: __________ Age: _____

Address: ________________________City ___________ State: ____Zip:_____

Phone: _______________ Cell:______________ E-Mail Address: _____________
(Please indicate with an * which way you would like us to contact you)

Doctor's Name: Address: Phone:

____
____
____
____

Allergies: Please check all that apply

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___seasonal allergies
___ sulfa drug ___ food allergies ___ no known allergies
Other: ____

Please describe the allergic reaction: ______________________________________
____

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

___ heart disease (example: congestive heart failure) ___ blood clotting problems
___ high cholesterol ___ high triglycerides ___ diabetes
___ high blood pressure ___ arthritis ___ cancer (type:________)
___ depression ___ headaches/migraines ___ epilepsy
___ ulcers ___ chronic pain ___ GERD
___ hypothyroidism ___ hyperthyroidism ___ asthma
___ emphysema ___ COPD ___ glaucoma
___ psoriasis ___ interstitial cystitis ___ fibromyalgia
___ irritable bowel syndrome (IBS/IBD)
___ other:____

____

PATIENT NAME: ____

Current Medications: Please list all medications you are currently taking. Include prescription medications, over the counter medications, and supplements/herbs.

Name of Medication	Dose	How often per day	Date Started

List Hormones previously taken:	Date Started	Date Stopped	Reason

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

Height:___________ Weight:___________ BMI (pharmacist will calculate):______
Bone Size ______ small _____ medium _____ large

Body Type: ______ apple ______ pear

Any recent dramatic weight changes? ______ No ______Yes
If Yes, describe:
How much? _________________________ Gain or Loss? _____________________
Over what time period? ____

How frequent are your bowel movements?_________________________________
____

Your weight at birth?____

PATIENT NAME: ____

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

Did you breastfeed your children? _____ No _____ Yes

Any miscarriages? _____ No _____ Yes

Have you had a hysterectomy? _____ No _____ Yes (Date of Surgery)______

Ovaries removed? _____ No _____ Yes

Please list any other recent surgeries (including gastric bypass)

____

____

____

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) ___________________

Colon Cancer __________________ 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: _________________

Age when your menstrual period began: _____ Since that time have you ever had what YOU would consider to be abnormal cycles? _____ No _____ Yes

If Yes, please explain: ____

____

____

____

When was your last period? ___________ How long did it last? _________________

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

If Yes, please explain symptoms: ____

____

____

____

____

PATIENT NAME: ____

Do you smoke? NO ______ YES _____ – how much and for how long_____________
How many caffeinated beverages do you drink per day? _______________________
Portion size____
How much water do you drink per day? _________ Portion size_________________
How many alcoholic beverages do you consume in an average week? _____________

How many meals a day do you eat? ____

Please describe your:
Typical breakfast: ____
____
Typical lunch: ____
____
Typical dinner: ____
____

Do you have trouble waking up in the mornings? _____ No _____ Yes
Do you take naps during the day? _____ No _____ Yes
Do you have trouble falling asleep at night? _____ No _____ Yes
Do you have trouble staying asleep? _____ No _____ Yes
Comments about sleep patterns: ____
____
____

Do you work outside the home? _____ No _____ Yes
How many hours per week? _____________________
Do you enjoy your job? ____
Do you find your job stressful? ____
Do you find your job satisfying? ____
Do you take care of small children, elderly, or disabled adults? _____ No _____ Yes
If Yes, explain:____
____
____

Do you have a hobby? _____ No _____ Yes
What activity relaxes you? ____
How often are you able to do this activity? ___________________________________
Is there a place in your home that you can go to relax and be alone? ____No ___Yes
Do you belong to a social or activity group outside of your family? ____ No ____ Yes
Do you have a current exercise routine? _____ No _____ Yes
If Yes, what kind of exercise and how often per week: ___________________
____
Comments:____
____
____
____

PATIENT NAME: ____

Please rate the following symptoms in severity from 0 to 3, 0 being absent and 3 being severe.

Symptom	Rating	Symptom	Rating
Hot Flashes	_________	Evening Fatigue	_________
Night Sweats	_________	Arthritis	_________
Vaginal Dryness	_________	Bone Loss	_________
Bladder Symptoms	_________	Rapid Aging	_________
Fibrocystic Breast	_________	Harder to Reach Climax	_________
Heavy/Irregular menses	_________	Decreased Sex Drive	_________
Fluid Retention	_________	Painful Intercourse	_________
Anxiety	_________	Dry Skin	_________
Depression	_________	Dry/Brittle Hair	_________
Foggy Thinking	_________	Dry/Brittle Nails	_________
Loss of Memory	_________	Hair Loss	_________
Irritability	_________	Constipation	_________
Mood Swings	_________	Pelvic Pain	_________
Breast Tenderness	_________	Increase in Facial Hair	_________
Trouble Sleeping	_________	Weight Gain - Hips	_________
Sugar Craving	_________	Weight Gain – Waist	_________
Headaches	_________	Cramps	_________
Morning Fatigue	_________	Breakthrough Bleeding	_________

Symptom Numerical Total___________

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 BHRT or this form.

____
____
____
____
____
____
____
____
____
____

PATIENT NAME: ____

LIFE STRESS TEST

In a now-famous American study from 1967, Dr. Thomas H. Holmes and Dr. Richard H. Rahe created a do-it-yourself stress test. They examined the stress - measured the Life Changes (LCU) – that induced by experiences ranging from death of a spouse to getting a traffic ticket. By adding the LCU values of the *past year*, you can predict the likelihood of stress related illness or accident.

CHANCE OF ILLNESS OR ACCIDENT WITHIN 2 YEARS.

Total LCU below 150 – 35%
Total LCU between – 150 to 300 – 51%
Total LCU over 300 – 80%

______Death of Spouse - 100
_____ Divorce – 73
_____ Marital Separation – 65
_____ Jail Term – 63
_____ Death of close family member – 63
_____ Personal injury or illness – 53
_____ Marriage – 50
_____ Fired from work – 47
_____ Marital reconciliation – 45
_____ Retirement – 45
_____ Change in family members health – 44
_____ Pregnancy – 40
_____ Sex difficulties – 39
_____ Addition to family – 39
_____ Business readjustment – 39
_____ Change in financial status – 38
_____ Death of close friend – 37
_____ Change to different line of work – 36
_____ Change in number of marital arguments – 35
_____ Mortgage or loan over $10.000 – 31
_____ Foreclosure of mortgage or loan – 30
_____ Change in work responsibilities – 29
_____ Trouble with in-laws – 29
_____ Outstanding personal achievement – 28
_____ Spouse begins or stops work – 26
_____ Starting or finishing school – 26
_____ Change in living conditions – 25
_____ Revision of personal habits – 24
_____ Trouble with boss – 23
_____ Change in work hours or conditions – 20
_____ Change in residence – 20
_____ Change in schools – 20
_____ Change in recreational habits – 19
_____ Change in social activities – 18
_____ Mortgage or loan under $10,000 – 17
_____ Change in sleeping habits – 16
_____ Change in number of family gatherings – 15
_____ Change in eating habits – 15
_____ Vacation – 13
_____ Christmas season – 12
_____ Minor violations of the law – 11

_____ YOUR TOTAL

This scale shows the kind of life pressure that you are facing. Depending on your coping skills or the lack thereof, this scale may predict the likelihood that you will fall victim to a stress related illness. This illness could be frequent tension headaches, acid indigestion, loss of sleep, to very serious illness like ulcers, cancer and migraines.

Daily practice of relaxation skills is very important for your wellness.
Take care of it now before serious illness erupts or an affliction becomes worse.