CONFIDENTIAL FEMALE HORMONE EVALUATION

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

Street City State Zip

Phone: _____ Email: _____

Height: _____ Weight: _____ Desired Weight: _____

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: _____

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

Name Strength How many tabs/ frequency

_____

_____

_____

_____

_____

_____

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

_____

_____

_____

Patient Name: _____

Current Prescription Medications (including hormones):

Medication Name and Strength Date Started How Often per day

_____

_____

_____

_____

_____

List Hormones Previously Taken: Date Started Date Stopped Reason

_____

_____

_____

_____

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

If you experienced any problems, please describe: _____

_____

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

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 heavy or light? _____ Any clots? ☐ Yes ☐ No

Patient Name: _____

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: _____

_____

	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____

Client comment: _____

RPH Notes: _____

Night Sweats:	_____	_____	_____	_____

Client comment: _____

RPH Notes: _____

Vaginal Dryness:	_____	_____	_____	_____

Client comment: _____

RPH Notes: _____

Incontinence:	_____	_____	_____	_____

Client comment: _____

RPH Notes: _____

Bleeding Changes:	_____	_____	_____	_____

Client comment: _____

RPH Notes: _____

Fibrocystic Breast:	_____	_____	_____	_____

Client comment: _____

RPH Notes: _____

Weight Gain:	_____	_____	_____	_____

Client comment: _____

RPH Notes: _____

Patient Name: _____

Fluid Retention: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Dry Skin/Hair: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Hair Loss: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Anxiety: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Depression: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Mood Swings: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Irritability: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Headaches: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Breast Tenderness: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Cramps: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Patient Name: _____

Difficulty Falling Asleep: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Difficulty Staying Asleep: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Fatigue: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Loss of Memory: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Foggy Thinking: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Acne: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Arthritis: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Decreased Sex Drive: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Harder to Reach Climax: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

Stress: _____ _____ _____ _____

Client comment: _____

RPH Notes: _____

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

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