



Phone: 509-455-9345

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#### **CONFIDENTIAL HORMONE EVALUATION**

Today's Date:				
Name:		Birthdate:	Age	<b>:</b>
Address:				
Street		City	State	Zip
Phone:		Email:		
Height:	Weight:	Desired Weight:		
How often and how m	nuch?			
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 ar		cribe the reaction that occurred		
Foods:				
Other:				
Over-the-Counter Me vitamins, herbals, and	-	ease list all non-prescription me	dications that you	are taking. (Include
Current Prescription I Medication name   St	=	ding hormones): ed   How often per day		

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## **Menstrual History**

Age at first period							
Length of cycle			Time be	tween cycl	es		
Menstrual Cramping?	□Yes	□No					
Menstrual Pain?	□Yes	□No					
Have you ever had prem If yes, please describe:		-	_				
Do you have other probl If yes, please describe:			•			•	
Use of hormonal birth co			rol pills □Pa	atch □Ni	uvaRing □OtI	ner	
Any problems with horm If yes, explain							-
Use of other contracepti	on?	□Yes □N	lo □Condom	ns □Diap	hragm □IUD	☐Partner vasector	ny
Obstetric Histo	ry						
□Pregnancies		□Miscarria	ges	□С	hildren		
☐Hysterectomy	_	□Oophored	ctomy				
Did you develop any pro	blems in	n or after pre	egnancy, for e	xample, to	xemia (high blo	ood pressure), diabet	es. post-
partum depression, issue		-		-		, , , , , , , , , , , , , , , , , , ,	,
If yes, please explain:							
Last Pap test:					 □Normal	 □Abnormal	
Last mammogram:					□Normal	□Abnormal	
Last bone density:			sults:		□Normal	☐High ☐Low	
Other tests and dates: _							_
Other Gynecological Syr	nptoms	: (Check if a	oplicable)				
□Endometriosis □Infe	rtility	□Fibrocysti	c breasts 🗆'	Vaginal infe	ection   Fibro	oids	
□Ovarian cysts □Pelv	ic inflan	nmatory disc	ease □Repr	oductive c	ancer		

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## **Menopause History** Are you in menopause? □Yes □No If yes, age at last period:\_\_\_\_\_ Was it surgical menopause? □Yes □No If yes, explain: Do you currently have symptomatic problems with menopause? (Check all that apply) □Hot flashes □Mood swings □Concentration/memory problems □Headaches □Joint pain □Vaginal dryness □Weight gain □Decreased libido □Loss of control of urine □Palpitations Are you on hormone replacement therapy? □Yes □No If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? **Current Hormone Usage:** Do you take hormones of any kind? □Yes □No If so, list (include birth control pills, HRT, or natural hormone (s): Brand **How Often** Hormone Dose **Date Started** If you are currently taking hormones, what specific symptoms are improved? Please list: If you are currently taking hormones, are you experiencing any unwanted side effects? Please list:

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# **Symptoms Questionnaire**

	Absent	Mild	Moderate	Severe
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Incontinence				
Bleeding Changes				
Fibrocystic Breast				
Weight Gain (waist)				
Weight gain (hips)				
Fluid Retention				
Dry skin/hair				
Thinning skin				
Hair Loss				
Brittle/dry nails				
Anxiety				
Depression				
Mood Swings				
Irritability				
Headaches				
Breast Tenderness				
Cramps				
Insomnia				
Sleep disturbances				
Fatigue				
Loss of Memory				
Foggy Thinking				
Acne				
Oily skin				
Sugar cravings				
Bone loss				
Decreased muscle mass				
Increased facial/body hair		<del></del>		
Arthritis				
Low libido				
Heart palpitations				
Low blood pressure				
Slow pulse rate			<del></del>	
Swelling/puffy eyes/face			<del></del>	
Stress				
Candida infection				
Cold hands/feet				
Other:				

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Primary Care Physician: _	
Phone:	_ Fax:

### **Medical History**

Please check appropriate box if applicable and provide date of onset

GASTROINTESTINAL	Date of onset:	CARDIOVASCULAR	Date of onset:
☐Irritable Bowel Syndrome		☐ Heart Attack	
☐ Inflammatory Bowel Disease		☐ Other Heart Disease	
□Crohn's disease		□Stroke	
Ulcerative Colitis		☐ Elevated Cholesterol	
Gastritis or Peptic Ulcer Disease		☐ Arrhythmia (irregular heart rate)	
☐GERD (reflux)		☐ Hypertension (high blood pressure)	
☐ Celiac Disease		☐ Rheumatic Fever	
Other		☐ Mitral Valve Prolapse	
- Ctric.		☐ Other:	
CANCER			
☐ Lung cancer		INFLAMMATORY/AUTOIMMUNE	
☐ Breast cancer		☐ Chronic Fatigue Syndrome	
☐ Colon cancer		☐ Rheumatoid Arthritis	
☐ Ovarian cancer		□SLE	
☐ Prostate cancer		☐Immune Deficiency Disease	
☐ Skin cancer		☐ Herpes-Genital	
		☐ Infectious Disease	
<b>GENITAL AND URINARY SYSTEMS</b>		☐ Poor immune function	
☐ Kidney stones		☐ Frequent infections	
□Gout		☐ Other:	
☐ Interstitial cystitis			
☐ Frequent urinary tract infections		SKIN CONDITIONS	
☐ Frequent yeast infections		□Eczema	
☐ Erectile/sexual Dysfunction		□ Psoriasis	
Other:		□Acne	
		□Melanoma	
MUSCULOSKELETAL/PAIN		□Rosacea	
☐ Osteoarthritis			
□Fibromyalgia		MEN'S HISTORY (for men only)	
☐ Chronic Pain		☐ Prostate Enlargement	
□ Other:		☐ Prostate infection	
		☐ Change in Libido	
FAMILY HISTORY (please specify rel	lationship)	□Impotence	
□ Breast cancer	, ,	☐ Difficulty obtaining an erection	
Ovarian cancer		☐ Difficulty maintaining an erection	
Uterine cancer		□ Nocturia (urination at night)	
☐ Fibrocystic breast		How many times at night?	
Heart disease		☐ Urgency/Change in Urinary Stream	
Osteoporosis		<ul> <li>Loss of Control of Urine</li> </ul>	
□ Diabetes		Have you had a PSA done? ☐ Yes	□ No
		PSA Level: □0-2 □2-4	□ 4-10 □>10

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