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
_____			
_____			
_____			
_____			
_____			

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: _____
_____

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.