

FEMALE HEALTH EVALUATION

DATE: _____

Name: _____ Birth Date: _____ Age _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Primary Care Physician:

Name: _____

Address: _____

Phone: _____

Physician Specialist we need to collaborate with regarding your therapy:

Name: _____ Specialty: _____

Address: _____

Phone: _____

Name: _____ Specialty: _____

Address: _____

Phone: _____

Name: _____ Specialty: _____

Address: _____

Phone: _____

FEMALE HEALTH EVALUATION

Medical History:

Allergies: Please list all that apply with reaction.

Drugs: _____

Foods: _____

Other: _____

Medications: (include OTC antacid, pain reliever, acid blocker, laxative, decongestant, cough suppressant, anti-diarrheal, sleep aid and any Prescribed medications)

Name	Dose	Route	How Often
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____
11.	_____	_____	_____
12.	_____	_____	_____

Nutritional/Natural Supplements:

1. Vitamins (ex. multiple or singles, such as B complex, E, C, D)

2. Minerals (ex. Calcium, magnesium, chromium)

3. Herbs (ex. Ginseng, ginkgo biloba, etc.)

4. Enzymes (ex. digestive formulas, papaya, bromelain, Coenzyme Q10, etc.)

5. Nutrition/protein supplements (ex. Shark cartilage, protein powders, amino acids, fish oils, etc.)

Current Hormone Therapies:

Name	Strength	Date started	How often per day
------	----------	--------------	-------------------

FEMALE HEALTH EVALUATION

List Hormones previously taken:

Name	Date started	Date stopped	Reason stopped
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Diseases: Check all that apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hormonal related issues |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Blood clotting problems | <input type="checkbox"/> Eye disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Lung Condition |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bipolar Disease |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Infection: explain type and treatment |
| <input type="checkbox"/> Lyme Disease | _____ |
| <input type="checkbox"/> Irritable Bowel Syndrome | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ |
- Other: _____

Have you had any of the following tests performed?

- | | | |
|--|------------|---------------|
| 1. <input type="checkbox"/> Mammogram | Date _____ | Results _____ |
| 2. <input type="checkbox"/> Pap Smear | Date _____ | Results _____ |
| 3. <input type="checkbox"/> Bone Density | Date _____ | Results _____ |

Surgical History:

Type	Date/Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

FEMALE HEALTH EVALUATION

OB/GYN History:

Onset of Menses _____ Regular/Irregular

Date of last menstrual period _____

How many days does it last? _____

How many days in between periods? _____

Do you have Premenstrual Syndrome (PMS)? YES/NO

If yes, check symptoms:

____ mood swings _____ fatigue

____ tender breasts _____ irritability

____ food cravings _____ depression

Have you ever used birth control pills? YES/NO. Any problems? YES/NO

If yes, describe: _____

pregnancies: _____

children and Ages: _____

Have you had difficulty conceiving? YES/NO

If yes, how long have you been trying? _____

Have you had a hysterectomy? YES/NO

If yes, when: _____

What was the cause of the hysterectomy? _____

Were your ovaries removed? YES/NO

Have you had a tubal ligation? YES/NO

If yes, when: _____

Any history of uterine prolapse? YES/NO

Any history of sexual transmitted diseases? YES/NO

If yes, type and last outbreak? _____

How frequently do you have a bowel movement? _____

Social History:

Do you use tobacco? ___yes___ no; If yes, How much and how often? _____

Do you use alcohol? ___yes___ no; If yes, How much and how often? _____

Do you use caffeine? ___yes___ no; If yes, How much and how often? _____

Family History:

Do you have a family history of any of the following?

1. ___ Heart Disease Family member (s) _____

2. ___ Diabetes Family member (s) _____

3. ___ Cancer Family member (s) _____

Type of Cancer (s) _____

4. ___ Uterine Cancer Family member (s) _____

5. ___ Ovarian cancer Family member (s) _____

6. ___ Breast Cancer Family member (s) _____

7. ___ Fibrocystic breast Family member (s) _____

FEMALE HEALTH EVALUATION

SYMPTOM SURVEY

Instructions: Please enter the appropriate response number to each question in the columns below

0 = None/Absent

1 = Mild or Rare

2 = Moderate

3 = Severe

Add an * (asterisk) if symptom is intermittent (Comes and goes)

- | | |
|---------------------------------|--------------------------------------|
| 1. ___ Hot flashes | 28. ___ Cold body temperature |
| 2. ___ Night sweats | 29. ___ Goiter |
| 3. ___ Vaginal dryness | 30. ___ Hoarseness |
| 4. ___ Incontinence | 31. ___ Dry or brittle hair |
| 5. ___ Bleeding changes | 32. ___ Brittle or breaking nails |
| 6. ___ Uterine fibroids | 33. ___ Constipation |
| 7. ___ Water retention | 34. ___ Slow heartbeat |
| 8. ___ Tender breasts | 35. ___ Rapid heartbeat |
| 9. ___ Fibrocystic Breast | 36. ___ Heart palpitations |
| 10. ___ Increased forgetfulness | 37. ___ Infertility problems |
| 11. ___ Foggy thinking | 38. ___ Acne |
| 12. ___ Tearful | 39. ___ Increase facial or body hair |
| 13. ___ Depressed | 40. ___ Scalp hair loss |
| 14. ___ Mood swings | 41. ___ Weight gain in the hips |
| 15. ___ Stress | 42. ___ Weight gain in the waist |
| 16. ___ Morning fatigue | 43. ___ High cholesterol |
| 17. ___ Evening fatigue | 44. ___ Elevated triglycerides |
| 18. ___ Difficulty sleeping | 45. ___ Decreased libido |
| 19. ___ Decreased stamina | 46. ___ Decreased muscle size |
| 20. ___ Anxiety | 47. ___ Thinning skin |
| 21. ___ Irritability | 48. ___ Ringing in the ears |
| 22. ___ Nervousness | 49. ___ Rapid aging |
| 23. ___ Fibromyalgia | 50. ___ Aches and pains |
| 24. ___ Allergies | 51. ___ Bone loss |
| 25. ___ Headaches | 52. ___ Panic attacks |
| 26. ___ Sugar cravings | 53. ___ ADD/ADHD |
| 27. ___ Dizziness | 54. ___ Compulsions/Addictions |

How old are you? _____

How old do you feel? _____

Height: _____ Weight: _____ BMI: _____ Goal Weight: _____

FEMALE HEALTH EVALUATION

Stress Reducers:

1. Do you practice Yoga/Meditation/Tai Chi/Diaphragmatic Breathing/Bio-feedback?

YES/NO

If yes, which one and how often? _____

2. Do you exercise?

YES/NO

If yes, what type and how often? _____

3. How much water intake/day? _____

Diet: Please bring the 3-day Diet Log with you to your consultation

Goals:

1. How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (BHRT)?

___ Doctor

___ Self

___ Friend

___ Family Member

___ Internet

___ Other: _____

2. What are your goals with Bioidentical Hormone Replacement Therapy (BHRT) and Treatment?

3. What Questions do you have about BHRT that we can address at your visit?

DISCLAIMER: By signing this form, I authorize the release of my medical information to share with other healthcare professionals for treatment purposes only.

Patient's Signature

Date

FEMALE HEALTH EVALUATION

THYROID EVALUATION

SYMPTOMS	ABSENT	MILD	MODERATE	SEVERE
Depression				
Weight Gain				
Cold extremities				
Cold Intolerance				
Feel Chilly				
Dry Hair				
Eczema				
Acne				
Puffy Eyelids/Face				
Brittle Nails				
Difficult Menses				
Constipation				
Mentally Sluggish				
Headache				
Insomnia				
Early Morning Fatigue				
Late Morning Fatigue				
Evening Fatigue				
Muscle Cramps				
Low Sex Drive				

Please check which box most correctly describes your symptoms.

1. When did the symptoms start?

2. Is there a family history of ANY thyroid disease? Please list whom and what type (goiter hypothyroidism, Graves' Disease, Hashimoto's Disease)

3. Have you ever been tested for thyroid problems? If yes, please list doctor, when diagnosed, and any therapy given.

4. Do you have any current thyroid lab results such as: TSH, Free T4, Free T3, Reverse T3, Lipid panel, Hemoglobin, ferritin, etc.? Please provide documentation if available.

Yes_____No_____

5. Have you had any other additional thyroid test performed (Urine Iodine Challenge, etc)?

FEMALE HEALTH EVALUATION

ADRENAL EVALUATION

Instructions: Please enter the appropriate response number to each question in the columns below.

0 = Never/Rarely

1 = Occasionally/slightly

2 = Moderate in Intensity or Frequency

3 = Intense/Severe or Frequent

(ranking your symptoms this way is important to our assessment)

I have not felt well since (Date) _____

When (Describe a specific event, if any) _____

Predisposing Factors

Past	Now	
		1. I have experienced long periods of stress that have affected my well being
		2. I have had one or more severely stressful events that have affected my well being
		3. I have driven myself to exhaustion
		4. I overwork with little play or relaxation for extended periods
		5. I have had extended, severe or recurring respiratory infections
		6. I have taken long term or intense steroid therapy
		7. I tend to gain weight, especially around the middle (spare tire)
		8. I have a history of alcoholism &/or drug abuse
		9. I have environmental sensitivities
		10. I have diabetes (type II, adult onset, NIDDM)
		11. I suffer from post-traumatic distress syndrome
		12. I suffer from anorexia
		13. I have one or more other chronic illnesses or diseases

Energy Patterns

Past	Now	
		1. I often have to force myself in order to keep going. Everything seems like a chore
		2. I am easily fatigued
		3. I have difficulty getting up in the morning (don't really wake up until about 10 AM)
		4. I suddenly run out of energy
		5. I usually feel much better and fully awake after the noon meal
		6. I often have an afternoon low between 3:00-5:00 PM
		7. I get low energy, moody or foggy if I do not eat regularly
		8. I usually feel my best after 6:00 PM
		9. I am often tired at 9:00 -10:00 PM, but resist going to bed
		10. I like to sleep late in the morning
		11. My best, most refreshing sleep often comes between 7:00-9:00 AM
		12. I often do my best work late at night or (very early in the morning)
		13. If I don't go to bed by 11:00 PM, I get a second burst of energy which often last until 1:00-2:00 AM