



Hormone Evaluation / Medical History

		Today's Date:	
Name:		Birthdate:	Age:
Address:			
City:		Province:	Postal Code
Phone:		Email:	
		Height:	Weight:

Gender: ___ Male ___ Female

Do you use tobacco? ___ Yes ___ No
 Do you use alcohol? ___ Yes ___ No
 Do you use caffeine? ___ Yes ___ No

How often and how much?

Doctor's Name:	Address:	Phone:

Drug Allergies and Reaction

Please List any Over the Counter Medications that you use on a regular basis (ASA, Zantac, laxatives, stool softeners, etc)

Please list any Vitamins, Herbals, Enzymes or other supplements you take

	Vitamins (multiple or single vitamins such as B, C, D, E, beta carotene)
	Minerals (Calcium, magnesium, chromium, colloidal minerals, various single minerals)
	Herbs (ginseng, ginkgo biloba, Echinacea, teas, tinctures, remedies, etc)
	Enzymes (digestive formulas, papaya, bromelain, CoEnzyme Q10, etc)
	Nutrition/ protein supplements (protein powders, amino acids, fish oils)
	Others (glucosamine, chondroitin, MSM, etc)

Medical Conditions / Diseases (please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Blood Clotting Problems |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis or joint problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Ulcers (stomach, esophagus) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Headaches, migraines |
| <input type="checkbox"/> Hormonal Related Issues | <input type="checkbox"/> Eye Disease (glaucoma etc) |
| <input type="checkbox"/> Lung Conditions (asthma, emphysema, COPD) | <input type="checkbox"/> Other: _____ |

Current Prescription Medications:

Medication Name	Strength	Date started	How often per day

List hormones previously taken

Medication Name	Date started	Date stopped	Reason to stop

Bone Size

Small Medium Large

Have you ever used oral contraceptives?

No Yes
 No Yes

Any problems?

If yes, describe the problem(s)

How many pregnancies have you had?

No
 No
 No
 No
 No

Any interrupted pregnancies

Have you had a hysterectomy?

Ovaries removed?

Have you had a tubal ligation?

Number of children
 Yes
 Yes Date of surgery: _____
 Yes
 yes Date: _____

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)	_____

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: _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles?

No Yes Date: _____

If yes, please explain (such as age when this occurred, symptoms):

When was your last period? _____

How many days did it last? _____

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

If yes, please explain symptoms:

How did you arrive at the decision to consider Hormone Therapy?

Doctor Self Friend/family other _____

Please list any questions below:
