

Hormone Evaluation

Please fill out all applicable information

Name:	Date:
Address:	
City, State, ZIP:	
Phone:	
Email:	

Medical Status

DOB:	General Health:	Blood Pressure:
Weight:	Excellent___ Good___ Fair___ Poor___	Cholesterol Level:
Height:	Energy Level:	Total_____ Date_____
Blood Type:	High___ Fairly High___ Low___	HDL___ LDL___ Triglycerides___

Known Medical Conditions: _____

Surgeries: _____

Current Medications: _____

Drug Allergies: _____

Do you smoke, and if so, how much and how often? _____

Family history of Diabetes? Yes___ No:___	Family history of Heart Disease? Yes___ No___	Family history of Hormonal Cancer? Yes___ No___
What type of cancer?		Who?

Have you had a bone density scan? Yes_____ No_____ Date_____	
Results:	
Physician's Name: _____	Date of last exam: _____

Have you had a mammogram? Yes_____ No_____ Date_____	
Results:	
OB/GYN's Name: _____	Date of last exam: _____



Do you take hormones of any kind? _____ List (include birth control pills and natural hormone cream):				
Type:	Dose:	Does it help your symptoms?	How often do you use them?	How long have you used them?

Have you tried other hormones? _____ If so, please list:			
Type:	Dose:	How did they affect you?	How long did you use them?

Gynecological History

Have you had a hysterectomy? Yes _____ No _____ If so, when? _____
Reason: _____

Do you have ovaries? Yes _____ No _____

Date of last pap smear _____ Results _____

Date of last period:
Describe your periods - for example, are your periods regular? How many days from the start of one period to the start of the next? Describe your flow. Any bleeding between periods? Do you have clots?

Do you have a history of vaginal/bladder infections? _____

Have you ever had a miscarriage(s)? _____ When: _____

Do you have children? Y / N If so, how many? _____

Do you have trouble sleeping? Yes _____ No _____

If yes, please describe- how long has this been a problem? Can you go to sleep, but then wake up, have mind racing at night, etc? _____



Do you have PMS symptoms? Yes _____ No _____

If so, when do symptoms start and stop: _____

PMS patients please fill in this section:

PMS - A	PMS - H	PMS - C	PMS - D
____ Nervous Tension	____ Weight Gain	____ Headache	____ Depression
____ Mood Swings	____ Water Retention	____ Cravings	____ Forgetfulness
____ Irritability	____ Breast Tenderness	____ Heart Palpitations	____ Crying
____ Anxiety	____ Bloating	____ Fatigue	____ Insomnia

Diet and Nutrition

Dietary Restrictions _____

Describe typical meal choices:

Breakfast _____

Lunch _____

Dinner _____

Do you get regular exercise? Yes _____ No _____ If yes, please describe _____

Stress Level: High _____ Moderate _____ None _____

Do you experience low blood sugar symptoms or hypoglycemia? (for example, do you get shaky, dizzy, or irritable if you eat or do not eat sugar?): _____

How much caffeine do you consume in an average day? (cups of coffee, caffeinated soda) _____

Current Supplements (include milligrams/dosages): _____

Number of regular bowel movements on a daily basis _____

Do you understand what bio-identical (natural) hormones are?

Very familiar _____ Somewhat familiar _____ Not familiar at all _____



Please rate all applicable symptoms on a scale of 1-10 (1 = no visible symptoms, 10 = extreme symptoms):

ESTROGENS

Estrogen Deficiency		Estrogen Excess	
Hot Flashes	Depressed	Mood Swings (PMS)	Fibrocystic Breasts
Night Sweats	Sleep Disturbances	Tender Breasts	Uterine Fibroids
Vaginal Dryness	Heart Palpitation	Water Retention	Weight Gain in Hips
Foggy Thinking	Bone Loss	Nervous	Bleeding Changes
Memory Lapses	Dry Skin/Hair	Irritable	Headaches
Incontinence	Headaches	Anxious	Heavy Periods
Tearful		Sleep Disturbances	Breast Cancer
		Cold Body Temp	Weight Gain in Waist
		Elevated Triglycerides	Low Libido

PROGESTERONE DEFICIENCY

Candida Infections	Fluid Retention	Sleep Disturbances	Break-thru Bleeding
Fibrocystic Breasts	Arthritis	Weight Gain	Fibroids
Hair Loss	Endometriosis	Heavy Periods	PMS
Anxiety	Stressed Easily	Irritability	Irregular Periods
Headaches	Water Retention	Cramps	Hypothyroid

ANDROGENS (DHEA-S and TESTOSTERONE)

Androgen Deficiency		Androgen Excess	
Low Libido	Depressed	Excessive Facial Hair	Oily Skin
Vaginal Dryness	Sleep Disturbances	Excessive Body Hair	Ovarian Cysts
Fatigue	Thinning Pubic Hair	Increased Acne	Hair Loss
Aches/Pains/Arthritis	Bone Loss	Breast Cancer	Nervous
Memory Lapses	Decreased Muscle Mass	Elevated Triglycerides	Irritable
Incontinence	Thinning Skin		
Heart Palpitations	Fibromyalgia		

CORTISOL IMBALANCE

Cortisol Deficiency		Cortisol Excess	
Fatigue	Cold Body Temp	Sleep Disturbances	Heart Palpitations
Sugar Cravings	Irritable	Bone Loss	Headaches
Allergies	Arthritis	Fatigue	Stress
Chemical Sensitivity	Heart Palpitations	Weight Gain/Waist	Cold Body Temp
Stress	Aches/Pains	Loss of Muscle Mass	Sugar Cravings
		Thinning Skin	Low Libido
		Elevated Triglycerides	Hair Loss
		Breast Cancer	Increased Facial Hair
		Irritable	Increased Body Hair
		Anxious	Acne
		Memory Lapse	Nervous

THYROID DEFICIENCY

Tired/Exhausted	Difficult to Concentrate	Nails Break/Brittle	Infertility Problem
Sad/Depressed	Mood Changes	Aches/Pains	Slowed Reflexes
Cold Body Temp	Swelling/Puffy	Low Libido	Constipation
Cold Hands/Feet	Eyes/Face	Heart Palpitations	Thick Tongue
Weight Gain	Low Blood Pressure	Sleep Disturbances	Slow Ankle Reflex
Can't Lose Weight	Slow Pulse Rate	Bone Loss	Hoarseness
Memory Lapse	Decreased Sweating	Decreased Muscle Mass	Afternoon Fatigue
Forgetful	Hair Dry/Brittle	Thinning Skin	
High Cholesterol	Hair Loss		



