Confidential Female Hormone Evaluation Form

www.HelpMyHormones.com

Scan and Send Confidentially to help@helpmyhormones.com

General Information

Name ______________________________________ Age _______ Birth Date _____________

Address ____

Cell Phone ______________________________ Home Phone ___________________________

Email _________________________________ Instagram _______________________________

Occupation _____________________________ Work Hrs. per Week _______ Retired? _______

Living Situation __________________________ Marital Status ___________________________

How Did You Hear About Natural Hormone Replacement? ______________________________

Do You Understand the Difference Between Natural and Synthetic Hormones? _____________

What Are Your Goals For Natural Hormone Replacement? ______________________________

____

____

What are your top 3 symptoms or reasons for seeking out help with your hormones?

1)

2)

3)

What are the main concerns you have about starting Natural Hormones Replacement?

Medical Status

General Health (Circle One): Excellent Good Fair Poor

List Current Diagnosis or Medical Conditions:

Diagnosis/Medical Condition Date of Diagnosis (if known)

-

-

-

Drug Allergies/Sensitivities

Drug Reaction

-

-

-

-

Food Allergies/Sensitivities

Food/Substance Reaction

-

-

-

-

Have you had an official food/allergen sensitivity test done in the past? Yes or No?

If Yes, please attach a copy of the most recent test if available.

If No, would you be interested in learning more about food sensitivity testing that is available? Yes or No?

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Current Medications and Duration of Treatment:

Medication Name	Strength	Dose	Since when?
-			
-			
-			
-			
-			

Current Vitamins/Herbs:

Medication Name	Strength	Dose	Since when?
-			
-			
-			
-			
-			

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Height _________ ft _________ inches Weight _________ lbs. Desired Weight ________lbs.

Have you struggled with weight issues? Yes or No

If yes, Please explain ____

____

____

____

Medical Status (Continued)

Labs - Please write down your most recent level OR for your convenience feel free to attach a copy of your results to this document to be sent to our office.

Total Cholesterol ____________ Date ____________

LDL ____________ Date ____________

HDL ____________ Date ____________

Blood Pressure ____________ Date ____________

Blood Glucose ____________ Date ____________

Thyroid:

TSH ____________ Date ____________

T3, Free ____________ Date ____________

T4, Free ____________ Date ____________

TPO ____________ Date ____________

Hormones:

Estradiol ____________ Date ____________

Progesterone ____________ Date ____________

Testosterone ____________ Date ____________

DHEA ____________ Date ____________

Cortisol ____________ Date ____________

Have You Ever Had a Mammogram ________ Date __________ Results _________________

Have You Ever Had a Bone Density Scan ________ Date __________ Results ____________

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Past Medical Conditions: (Circle All That Apply)

Heart Trouble	High Blood Pressure	Stroke	Epilepsy
Kidney Trouble	Fractures	Arthritis	Chronic Fatigue
Fibromyalgia	Varicose Veins	Diabetes	Clotting Defects
Colitis	Gallbladder Trouble	Asthma	Eating Disorder

Cancer (If so, what kind) ___________________________________ Active or In Remission

Auto-Immune Conditions

Name	Time of Diagnosis	Active/In Remission
-		
-		
-		

Stress

What would best describe your level of stress:

Mild	Moderate	Severe	Extreme

What have been your major sources of stress currently and within the last 2 years?

-

-

-

Are there specific times of the day when you feel most stressed?

____

What do you do, if anything, to deal with stress?

____

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Care Provider Information

Primary Health Care Provider: Dr.__________________________ Phone # ________________

Address____

Phone Number ______________________ Years as your Physician _________

Dietary and Social Information

Typical Breakfast Foods:

Typical Lunch Foods:

Typical Dinner Foods:

Typical Snack Foods:

Do you ever feel “Hangry” (Anger related to hunger)? Yes or No

Do you suffer from symptoms associated with blood sugar fluctuations? Yes or No

Do you diet frequently: Yes or No

Do you count calories frequently: Yes or No If so, what is your caloric daily goal _________

Do You Drink Alcoholic Beverages? (Yes/No) If So, What Kinds, How Much, And How Often?

Do You Smoke? (Yes/No) If So, What Kind, How Much, And How Often?

Do You Use Drugs? (Yes/No) If So, What Kind, How Much, And How Often?

Do You Exercise? (Yes/No) If So, What Kind, How Much, And How Often?

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Family Medical History

Father (Living/Deceased) Age ______ Medical History:

Mother (Living/Deceased) Age ______ Medical History:

Brother/Sister (Living/Deceased) Age ______ Medical History:

Brother/Sister (Living/Deceased) Age ______ Medical History:

Brother/Sister (Living/Deceased) Age ______ Medical History:

Brother/Sister (Living/Deceased) Age ______ Medical History:

Other Pertinent Family Medical History:

Gynecological History

Age at First Period __________ if you are Menopausal List Date At Last Period __________

Date Of Last Pelvic Exam _________ & Pap Smear ________ Results? _______________

Have You Ever Had An Abnormal Pap? ____________Treatment? ____________________

Are You Sexually Active? _________ Are You Trying to Get Pregnant?___________________

Current Birth Control Method: ________________________________How Long?__________

Problems with Birth Control? ____

Past Birth Control and Any Related Problems:____

How Many Days from the Start of One Period to the Start of the Next? ____________________

Number of Days of Flow __________________ Amount of Bleeding ______________________

Premenstrual Symptoms: ____

Starting and Ending When: ____

Any Current Changes in Your Normal Cycle? ____

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Gynecological History (continued)

Any Bleeding Between Periods: ________________________ When: ______________________

Any Pelvic Pain, Pressure, or Fullness? __________

Any Unusual Vaginal Discharge or Itching? ________ Describe: __________________________

Treatment: ____

Age at First Pregnancy: ____________ How Many Full Term Pregnancies? ________________

Do You Experience Any Problems? ____

Any Interrupted Pregnancies? ____

Have You Had A Tubal Legation? ____________ When? _______________________________

Have You Had Any Part or Whole Ovary Removed? __________ When? __________________

Have You Had a Hysterectomy? ______ When? _____________________________________

Do Your Ovaries Remain? ____

How would you describe how you felt during your last or most typical cycles:

Week 1 -

Week 2 -

Week 3 -

Week 4 -

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List and Explanation of Symptoms

Headaches (P, E): Absent Mild Moderate Severe
Explain:

Low Libido (P, D): Absent Mild Moderate Severe
Explain:

Anxiety (P, E): Absent Mild Moderate Severe
Explain:

Swollen Breast (P, E): Absent Mild Moderate Severe
Explain:

Fuzzy Thinking (P): Absent Mild Moderate Severe
Explain:

Depression (P, E): Absent Mild Moderate Severe
Explain:

Food Cravings (P): Absent Mild Moderate Severe
Explain:

Irritability (P): Absent Mild Moderate Severe
Explain:

Insomnia (P): Absent Mild Moderate Severe
Explain:

Cramps (P): Absent Mild Moderate Severe
Explain:

Emotional Swings (P): Absent Mild Moderate Severe
Explain:

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Painful Breast (P): Absent Mild Moderate Severe
Explain:

Weight Gain (P): Absent Mild Moderate Severe
Explain:

Bloating (P): Absent Mild Moderate Severe
Explain:

Low Concentration (P): Absent Mild Moderate Severe
Explain:

Hot Flashes (E): Absent Mild Moderate Severe
Explain:

Difficulty Breathing (E): Absent Mild Moderate Severe
Explain:

Vaginal Dryness (E): Absent Mild Moderate Severe
Explain:

Dry Hair/ Skin (E): Absent Mild Moderate Severe
Explain:

Memory Loss (E): Absent Mild Moderate Severe
Explain:

Urinary Infections (E): Absent Mild Moderate Severe
Explain:

Heart Palpitations (E): Absent Mild Moderate Severe
Explain:

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Yeast Infections (E): Absent Mild Moderate Severe
Explain:

Painful Intercourse (E): Absent Mild Moderate Severe
Explain:

No Orgasm (E): Absent Mild Moderate Severe
Explain:

Water Retention (D): Absent Mild Moderate Severe
Explain:

Fatigue (D): Absent Mild Moderate Severe
Explain:

Fibrocystic Breasts (D): Absent Mild Moderate Severe
Explain:

Heavy Menses (D): Absent Mild Moderate Severe
Explain:

Irregular Menses (D): Absent Mild Moderate Severe
Explain:

Uterine Fibroids (D): Absent Mild Moderate Severe
Explain:

Sweet Cravings (D): Absent Mild Moderate Severe
Explain:

Weight Gain (D): Absent Mild Moderate Severe
Explain:

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