www.TestMyHormones.com

Natural Hormone Replacement
Confidential Evaluation for Women

When Completed Fax To 714-572-2277 and our staff will contact you to discuss potential testing/consultation options.

General Information

Name____ Age_______ Birth Date _______________

Address____

Home Phone____________________________________ Alt. Ph.__________________________________

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? _______________________________________

Medical Status

General Health (Circle One): Excellent Good Fair Poor Height________ Weight ________

List Current Diagnosis or Medical Conditions:

Drug Allergies:

Food Allergies:

Current Medications and Duration of Treatment:

Current Vitamins/Herbs:

Medical Status (Continued)

Labs: Cholesterol ____________ Date ____________ Blood Pressure ____________ Date ____________
Blood Glucose _____________ Date _____________ Thyroid (Circle) High Average Low

Have You Ever Had a Mammogram ________ Date __________ Results _________________________

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

Have You Had Your Hormone Levels Measured Recently __________ Date _________ Results _________

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Past Medical Conditions: (Circle All That Apply)

Heart Trouble High Blood Pressure Stroke Varicose Veins Diabetes Clotting Defects

Epilepsy Kidney Trouble Fractures Arthritis Colitis Gallbladder Trouble Asthma

Chronic Fatigue Fibromyalgia Eating Disorder Cancer

Health Care Provider ___________________________________ Phone # __________________________

Address ____

Phone Number _________________________________ Years as your Physician ____________________

Your Insurance Provider __________________________________ ID # _____________________________

Name of Primary Insured __________________________________ Ins. Phone # _____________________

Dietary and Social Information

Typical Breakfast Foods:

Typical Lunch Foods:

Typical Dinner Foods:

Typical Snack Foods:

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?

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? ____

Any Bleeding Between Periods: _______________________ When: _______________________________

Any Pelvic Pain, Pressure, or Fullness? __________ Describe: ___________________________________

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? ____

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: ____

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: ____

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 Breast **(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: ____

Low Thyroid **(D)** Absent Mild Moderate Severe

Explain: ____