Stuart Ellis Pharmacy
Confidential Hormone Evaluation

General Information

Date: ________________

Name: ______________________________Birthdate: _____________ Age: ______

Address:____

____

City: _______________________________ Postal Code: _______________

Phone (Home): ____________________ Work: _______________

Email: ______________________

How did you hear about Bio-identical Hormone Replacement Therapy?

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What are your goals for Bio-identical Hormone Replacement Therapy?

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____

Medical History

Gender: Male ❑ Female ❑ Height: _______ Weight: _______

Current Health Care Providers Name & Phone Number:

____

____

____

____

Drug Allergies:

____

____

____

Other Allergies: (i.e. food and chemical sensitivities):

____

____

____

Current medical conditions:

Please check all that apply

	Heart disease (i.e. CHF)		Depression
	High cholesterol or lipids		Epilepsy
	High blood pressure		Headaches/migraines
	Stroke		Eye Disease (i.e. glaucoma)
	Ulcers (stomach, esophagus)		Osteoporosis
	Hypothyroidism		Cancer Type:
	Hyperthyroidism		
	Hormonal related issues		Fibromyalgia
	Lung disease (i.e. asthma, COPD)		Chronic Fatigue
	Blood clotting problems		Kidney/Bladder problems
	Diabetes		Liver problems
	Arthritis		Eating disorder
	Irritable Bowel Syndrome		Other:

Have you had your cholesterol checked?: ______ Date: _______ Results: _________
Have you had a PAP smear? _______ Date: _______ Results: ________
Have you had a mammogram? _______ Date: _______ Results: ________
Have you had a bone density scan? _______ Date: _______ Results: _______
Have you had your thyroid checked? _______ Date: ________ Results: __________
Bone Size: Small _______ Medium ______ Large ________

Medication History:

Current Prescription Medications			
Name	Strength	Date started	How often per day

Current Over-the-Counter Medications			
Name	Strength	Date Started	How often per day

Current Natural Supplements, Vitamins and Minerals			
Name	Strength	Date Started	How often per day

Hormones Currently or Previously Taken			
Name & Strength	Date started	Date Stopped	Reason

Gynecological History:

Age at first period: ______ Date of last period: _____
How many days from start of one period to the start of the next: ________
Number of Days of flow: ______ Amount of bleeding: _________________________
Amount of cramps:____
PMS Symptoms:____
Bleeding or spotting between periods? ____
Vaginal Discharge or itching?____
Age at first pregnancy? ______ How many full-term pregnancies? ___________
Any interrupted pregnancies (abortions or miscarriages)? __________________
Have you had a tubal ligation? _________ When? ________
Have you had a hysterectomy? _________ When? _________
Do your ovaries remain? ___________________________________
Have you ever used oral contraceptives? ❑Yes ❑No
Any problems? ❑Yes ❑No
If YES, please describe.
____
____

Family History:

Do you have a family history of any of the following? (List family member)
Uterine Cancer ____
Ovarian Cancer ____
Fibrocystic Breast ____
Breast Cancer ____
Heart Disease ____
Osteoporosis ____

Please list family members who died of important diseases (see above) and their age at the time of death.
____
____
____
____

Lifestyle:

Occupation: _________________________ Full-time ___ Part-time ______ Retired ______ Unemployed _____
Living Situation: Spouse___ Alone ___ Partner ___ Friends _____ Parents ___ Children ____ Other____
Status: Married ___ Single ___ Divorced ___ Widowed ___
Pets: ____

Dietary Restrictions:____
Meal Choices: Describe what you would typically eat in a day.
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: __________________________Cravings:__________________________________
Daily Water Intake: ________________________

Do you get routine physical exercise: ____ What type?_________________________
Do you use tobacco products? ____ How much? ____ Previously? ____ How long?__
Do you use alcohol products? ____ How much? ____ Previously?____
Do you use caffeine containing products? _____ What type? ______ How much? ___

Symptoms:

Rate your current status for each symptom by checking the appropriate modifier.

	Absent	Mild	Moderate	Severe
Headaches				
Depression				
Anxiety				
Swollen or painful breasts				
Moodiness				
Fuzzy Thinking				
Fatigue				
Food Cravings				
Irritability				
Insomnia				
Cramps				
Emotional Swings				
Weight Gain				
Bloating				
Hot Flashes				
Shortness of Breath				
Night Sweats				
Vaginal Dryness				
Dry Hair/Skin				
Hair Loss				
Short Term Memory Loss				
Frequent Urinary Tract Infections				
Heart Palpitations				
Frequent Yeast Infections				
Constipation				
Painful intercourse				
Inability to Reach orgasm				
Low Libido				
Irregular Menses				
Water retention				
Uterine fibroids				