

**Stuart Ellis Pharmacy
Confidential Hormone Evaluation**

General Information

Name: _____ Birthdate: _____ Date: _____
Age: _____
Address: _____

City: _____ Postal Code: _____
Phone (Home): _____ Work: _____
Email: _____

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

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

Medical History

Gender: Male Female Height: _____ Weight: _____
Current Health Care Providers Name & Phone Number:

Drug Allergies:

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

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: _____
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				
Vaginal Dryness				
Painful intercourse				
Inability to Reach orgasm				
Low Libido				
Irregular Menses				
Water retention				
Uterine fibroids				

