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Date_____

Female Information and Health Summary

Name_____ Date of Birth _____

Address_____City/State/ZIP_____

Home Phone (_____)-_____-_____ Cell (_____)-_____-_____ Fax (____)-_____-_____

Email address _____Who referred you to us? _____

Please List Your Healthcare Providers & Indicate Which Doctor to Contact Regarding Hormone Therapy

Name_____
Specialty _____
Address _____
Phone _____
Fax_____

Name_____
Specialty_____
Address_____
Phone_____
Fax_____

Any Known Medication Allergies? _____

Please List Any Medications You Are **Currently** Taking, Including Vitamins, Natural Supplements, or Non-Prescription Medications (**Doses of any hormones you are taking are necessary, because that is the current baseline to make a recommendation to your doctor):**

_____

_____

_____

_____

Is your **Diet:** 1 Bad 2 Fair 3 Good 4 Very Good (please circle)

Exercise: type of activity, how frequent, and for how long?_____

Employer and Job Title _____

Circle your perceived stress level: 1 None 2 Mild 3 Moderate 4 Severe 5 Extremely Severe

Family History

Please check all that apply:

___ Cancer (type)

- ___ Breast_____ Relationship to you_____
- ___ Uterine_____ Relationship to you_____
- ___ Ovarian_____ Relationship to you_____
- ___ Other_____ Relationship to you_____

___ Diabetes; type_____ Relationship to you _____
___ Heart Disease_____ Relationship to you_____
___ Osteoporosis_____ Relationship to you _____
___ Alzheimer's Disease_____ Relationship to you_____
___ Thyroid Disease_____ Relationship to you_____

Past or Present Medical Conditions

Please check all that apply:

___ Asthma	___ Fibromyalgia	___ Fractures _____
___ Cancer (type:_____	___ Arthritis	___ Epilepsy
___ Depression	___ Varicose Veins	___ Liver Disorder
___ Diabetes (type:_____)	___ Kidney Disorder	___ Eating Disorder
___ Headaches/Migraines	___ Thyroid Disorder	___ Ulcers
___ Heart Condition _____	___ High Cholesterol	___ Chronic Fatigue Syndrome
___ High Blood Pressure	___ Clotting Disorder	___ Other _____
___ Osteoporosis/Osteopenia	___ Gallbladder Disease	

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Gynecological History

- Have you had a hysterectomy? ___Yes ___No
  If Yes,when?_____
- Have your ovaries been removed? ___Yes ___No
  If Yes, when? _____
- Have you ever had a tubal ligation? ___Yes ___No
  If Yes, when?_____
- Have you ever had an abnormal pap? ___Yes ___No
  If Yes, when?_____
- Do you perform self-breast exams? ___Yes ___No
  How often?_____

Obstetrical History

- Are you sexually active? ___Yes ___No
- Are you trying to get pregnant? ___Yes ___No
- Current method of birth control? _____ How long ?_____
- Past method of birth control &/or any problems? _____
- Have you ever had children? ___Yes ___No
- Number of Pregnancies_____ Deliveries_____ Multiple Births_____

Have you ever had . . . (check all that apply)

___ Sexual Problems
___Cervical Dysplasia
___ Vaginal Dryness
___ Vaginal Infections
___Pelvic Infections
___ Increased facial &/or body hair growth
___Cervical Cancer
___ Painful Intercourse
___Uterine fibroids
___Lack of Energy
___HSV (vaginal herpes)
___ Lack of Sex Drive
___Ovarian Cysts
___Breast fibroids
___ HPV(vaginal warts)
___ Inability to reach climax

Menstrual History

Present state of Menstruation

___Regular ___Irregular ___Sporadic
___ Light ___Heavy ___No Periods

Have you missed periods altogether? ___Yes ___No

When was your last period? _____ How long is your cycle?_____

Do you have bleeding between periods? ___Yes ___No

Have you ever taken hormones before? ___Yes ___No

If so, please list **previous and current hormones taken, **doses**, and any side effects here:

_____

Have you tried alternative therapies or taken any herbal or homeopathic products?

_____

How did you become interested in bio-identical hormones?

Please check ALL symptoms below that apply (this is very important to the evaluation process)

Symptoms of **low Progesterone**?

__ Swollen Breasts
__ Anxiety/Irritability
__ Irregular menses
__ Infertility
__ Weight Gain
__ Mood Swings
__ PMS
__ Joint Pain
__ Food Cravings
__ Headaches ___per week
__ Cramping
__ Acne
__ Low Sex Drive
__ Depression
__ Fuzzy Thinking
__ Low Energy

Symptoms of **low Estrogen**?

__ Hot Flashes
__ Dry Skin
__ Foggy Thinking
__ Painful Intercourse
__ Night Sweats ___per week
__ Yeast Infections
__ Bone Loss
__ Weight Gain
__ Insomnia ___per week
__ Heart Palpitations
__ Low Sex Drive
__ Vaginal Dryness/Atrophy
__ Memory Lapses
__ Depression
__ Headaches ___per week

Symptoms of **low Testosterone?**

__ Depression
__ Joint Pain
__ Heart Palpitations
__ Fibromyalgia
__ Urinary Incontinence
__ Low Sex Drive
__ Memory Lapses
__ Vaginal Dryness
__ Low Energy
__ Bone Loss
__ Muscle Weakness
__ Thinning Skin/Scalp Hair

Other Symptoms_____

_____

Top 3 symptoms you'd like resolved_____

Circle the number that best describes the DEGREE of symptom intensity you have experienced over the past month(s)

None	Mild	Moderate	Severe
0	1	2	3

1. Hot flashes, perspiration, and/or chilly sensations?

0 1 2 3

2. Insomnia or restless, fragmented sleep?

0 1 2 3

3. Irritability, feeling anxious or apprehensive?

0 1 2 3

4. Feeling of depression and unhappiness and/or being miserable without obvious reason?

0 1 2 3

5. Sensations of dizziness or swimming in the head?

0 1 2 3

6. Feeling of weariness of mind and body with desire for rest; disinclination to make further efforts?

0 1 2 3

7. Pain of any kind affecting joints or muscles?

0 1 2 3

8. Headaches of any kind (tension, migraine, etc)?

0 1 2 3

9. Quickening or acceleration of heartbeat or fluttering/pounding heartbeat in a sitting or resting position?

0 1 2 3

10. Thinning or loss of scalp hair?

0 1 2 3

Have you ever had . . .

Never	Infrequently	Sometimes	Most of Time	Always
0	1	2	3	4

1. Vaginal burning or itching?

0 1 2 3 4

2. Painful urination or increased frequency or urination?

0 1 2 3 4

3. Leaking of urine when coughing, laughing, sneezing, or on hard work?

0 1 2 3 4

4. Leaking of urine when walking, running, climbing steps, or on light work?

0 1 2 3 4

5. Leaking of urine, regardless of activity, even when in a lying position?

0 1 2 3 4