

Seasons Healthcare

Hormone Evaluation / Medical History

Today's Date: _____

Name: _____ SS #: _____ Birth date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ (Home) _____ (Work) _____ (Cell)

Gender: ___ Male ___ Female E-Mail Address: _____

Occupation: _____ Employer: _____

Marital Status: _____ Name of Spouse/Partner: _____

Referred by: _____

Emergency Contact: _____ Relationship: _____

Home Telephone: _____ Work Telephone: _____

Why have you come to the office today? _____

Please describe your problem, including where it is, how severe it is, and how long it's lasted: _____

Current Doctor's Name: _____ **Address:** _____ **Phone:** _____ **Specialty:** _____

Allergies: Please check all that apply.

___ Penicillin ___ Morphine ___ Dye Allergies ___ Pet Allergies

___ Codeine ___ Aspirin ___ Nitrate Allergy ___ Seasonal Allergy

___ Sulfa Drug ___ Food Allergies ___ No Known Drug Allergies

Other: _____

Please describe the allergic reaction you experienced and when it occurred?

Current Prescription Medications: _____ currently **not** taking any medication

Medication Name _____ **Strength** _____ **How often per day?** _____ **Date Started** _____

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

- Pain Reliever
- Aspirin
- Acetaminophen (Ex: Tylenol)
- Ibuprofen (Ex: Motrin)
- Naproxen (Ex: Aleve)
- Ketoprofen (Ex: Orudis KT)
- Cough Suppressant (Ex: Robitussin DM)
- Antihistamine Product (Ex: Chlor-Trimeton)
- Decongestant Product (Ex: Sudafed)
- Combination Product (Cough+Cold Reliever) (Ex: Triaminic DM.)
- Sleep Aids (Ex: Excedrin PC, Unisom, Sominex, Nytol)
- Antidiarrheals (Ex: Imodium, Pepto Bismol, Kaopectate)
- Laxatives/Stool Softeners (Ex: Doxidan, Correctol, etc.)
- Diet Aids/Weight Loss Products (Ex: Dexatril)
- Antacids (Ex: Maalox, Mylanta)
- Acid Blockers (Ex: Tagamet HB, Pepcid C, Zantac 75)
- Other (Please list) _____

Nutritional/Natural Supplements: Please identify and list the products you are using.

- Vitamins (Ex: Multiple or simple vitamins such as B complex, E, C, Beta Carotene)
- Minerals (Ex: Calcium, Magnesium, Chromium, Colloidal Minerals, Various Single Minerals.)
- Herbs (Ex: Ginseng, Ginkgo Biloba, Echinacea, Other Herbal Medicinal Teas, Tinctures, etc.)
- Enzymes (Ex: Digestive formulas, Papaya, Bromelain, CoEnzyme Q10, etc.)
- Nutrition/Protein Supplements (Ex: Shark Cartilage, Protein Powers, Amino Acids, Fish Oils)
- Others (Ex: Glucosamine, etc.)

Medical Conditions/Diseases: Please check all that apply to you.

- Heart Disease (Ex. Congestive Heart Failure)
- High Cholesterol or Lipids (Ex: Hyperlipidemia)
- High Blood Pressure (Ex: Hypertension)
- Cancer *Type:* _____
- Ulcers (Stomach, Esophagus)
- Thyroid Disease
- Hormonal Related Issues
- Lung Condition (Ex: Asthma, Emphysema, COPD)
- Blood Clotting Problems
- Diabetes
- Arthritis or Joint Problems
- Depression
- Epilepsy
- Headaches/Migraines
- Eye Disease (Glaucoma, etc)
- Other :(Please list) _____

Family History: Please check all that apply & list which relative(s):

- Heart Disease (Ex. Congestive Heart Failure) _____
- High Blood Pressure (Ex: Hypertension) _____
- High Cholesterol or Lipids (Ex: Hyperlipidemia) _____
- Diabetes _____
- Lung Condition (Ex: Asthma, Emphysema, COPD) _____
- Blood Clotting Problems _____
- Ulcers (Stomach, Esophagus) _____
- Cancer _____
- Depression _____
- Thyroid Disease _____
- Headaches/Migraines _____
- Other: _____

Social History:

- | | | | |
|----------------------------|------------------------------|-----------------------------|--------------------------------|
| Do you use tobacco? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | How often and how much? |
| Do you use alcohol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Do you use caffeine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Do you use a seat belt? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| Do you exercise regularly? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

Surgical History/Hospitalization:

Date

Patient Name: _____

Women's Health Profile/Questionnaire Obstetric History

	Number		Number		Number
Pregnancies		Abortions		Miscarriages	
Premature Births		Live Births		Living Children	

No	Birth Date	Baby's Weight	Baby's Sex	Weeks Pregnant	Type of Delivery (Vaginal, Cesarean)	Complications?
1.						
2.						
3.						
4.						
5.						

Have you had a Hysterectomy? ___ No ___ Yes (Date of Surgery) _____

Ovaries Removed? ___ No ___ Yes

Have you had a Tubal Ligation? ___ No ___ Yes (Date) _____

Do you have a family history of any of the following?

- Uterine Cancer ___ Family Member(s) _____
- Ovarian Cancer ___ Family Member(s) _____
- Fibrocystic Breast ___ Family Member(s) _____
- Breast Cancer ___ Family Member(s) _____
- Heart Disease ___ Family Member(s) _____
- Osteoporosis ___ Family Member(s) _____

Have you had any of the following tests performed? Check those that apply & date of last test.

Mammography ___ No ___ Yes Date: _____ Results: _____

Do you do regular breast self-examinations? _____

Pap Smear ___ No ___ Yes Date: _____ Results: _____

Have you ever had an abnormal Pap Test? _____

Last Normal Menstrual Period (First Day): _____

Age periods began? _____

Length of Periods (Number of Days of Bleeding): _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? _____

Are you Sexually Active?

Present Method of Birth Control: _____

Have you ever used oral contraceptives? ___ No ___ Yes
Any problems? ___ No ___ Yes (Describe) _____

Patient Name: _____

List Hormones previously taken.	Date Started	Date Stopped	Reason

How did you arrive at the decision to consider Bio-identical Hormone Replacement Therapy?
___ Doctor ___ Self ___ Friend/Family Member ___ Other

What are your goals with taking BHRT?

Please write down any questions you have about BHRT.

Please check all that apply & rate **Mild, Moderate, or Severe.**

Fibrocystic Breast		
Weight Gain		
Heavy / Irregular Menses		
Hot Flashes		
Dry Skin / Hair		
Anxiety		
Depression		
Night Sweats		
Vaginal Dryness		
Headaches		
Irritability		
Mood Swings		
Breast Tenderness		
Sleep Disturbances / Insomnia		
Cramps		
Fluid Retention		
Breakthrough Bleeding		

Fatigue		
Loss of Memory		
Bladder Symptoms		
Arthritis		
Harder to Reach Climax		
Decreased Sex Drive		
Hair Loss		

Patient Name: _____

Review of Systems

Physician's Notes

Constitutional

Weight Loss	___ Now	___ Past	___ Not Sure	_____
Weight Gain	___ Now	___ Past	___ Not Sure	_____
Fever	___ Now	___ Past	___ Not Sure	_____
Fatigue	___ Now	___ Past	___ Not Sure	_____
Change in Height	___ Now	___ Past	___ Not Sure	_____

Eyes

Double Vision	___ Now	___ Past	___ Not Sure	_____
Spots Before Eyes	___ Now	___ Past	___ Not Sure	_____
Vision Changes	___ Now	___ Past	___ Not Sure	_____
Glasses/Contacts	___ Now	___ Past	___ Not Sure	_____

Ear, Nose, and Throat

Earaches	___ Now	___ Past	___ Not Sure	_____
Ringing in Ears	___ Now	___ Past	___ Not Sure	_____
Sinus Problems	___ Now	___ Past	___ Not Sure	_____
Sore Throat	___ Now	___ Past	___ Not Sure	_____
Mouth Sores	___ Now	___ Past	___ Not Sure	_____
Dental Problems	___ Now	___ Past	___ Not Sure	_____

Cardiovascular

Painful Breathing	___ Now	___ Past	___ Not Sure	_____
Chest Pain/Pressure	___ Now	___ Past	___ Not Sure	_____
Difficulty Breathing on Exertion	___ Now	___ Past	___ Not Sure	_____
Swelling of Legs	___ Now	___ Past	___ Not Sure	_____
Rapid or Irregular Heartbeat	___ Now	___ Past	___ Not Sure	_____

Respiratory

Wheezing	___ Now	___ Past	___ Not Sure	_____
Spitting up Blood	___ Now	___ Past	___ Not Sure	_____
Shortness of Breath	___ Now	___ Past	___ Not Sure	_____
Chronic Cough	___ Now	___ Past	___ Not Sure	_____

Gastrointestinal

Frequent Diarrhea	___ Now	___ Past	___ Not Sure	_____
Bloody Stool	___ Now	___ Past	___ Not Sure	_____
Nausea/Vomiting/Indigestion	___ Now	___ Past	___ Not Sure	_____
Constipation	___ Now	___ Past	___ Not Sure	_____

Involuntary Loss of Gas or Stool ___ Now ___ Past ___ Not Sure _____

Neurologic

Dizziness ___ Now ___ Past ___ Not Sure _____
Seizures ___ Now ___ Past ___ Not Sure _____
Numbness ___ Now ___ Past ___ Not Sure _____
Trouble Walking ___ Now ___ Past ___ Not Sure _____
Severe Memory Problems ___ Now ___ Past ___ Not Sure _____
Frequent/ Severe Headaches ___ Now ___ Past ___ Not Sure _____

Patient Name: _____

Genitourinary

Blood in Urine ___ Now ___ Past ___ Not Sure _____
Pain with Urination ___ Now ___ Past ___ Not Sure _____
Strong Urgency to Urinate ___ Now ___ Past ___ Not Sure _____
Frequent Urination ___ Now ___ Past ___ Not Sure _____
Incomplete Emptying ___ Now ___ Past ___ Not Sure _____
Involuntary Urine Loss ___ Now ___ Past ___ Not Sure _____
Urine loss when Coughing/Lifting ___ Now ___ Past ___ Not Sure _____
Abnormal Bleeding ___ Now ___ Past ___ Not Sure _____
Painful Periods ___ Now ___ Past ___ Not Sure _____
Premenstrual Syndrome (PMS) ___ Now ___ Past ___ Not Sure _____
Painful Intercourse ___ Now ___ Past ___ Not Sure _____
Fibroids ___ Now ___ Past ___ Not Sure _____
Infertility ___ Now ___ Past ___ Not Sure _____
Des Exposure ___ Now ___ Past ___ Not Sure _____
Abnormal Vaginal Discharge ___ Now ___ Past ___ Not Sure _____

Skin

Rash ___ Now ___ Past ___ Not Sure _____
Sores ___ Now ___ Past ___ Not Sure _____
Dry Skin ___ Now ___ Past ___ Not Sure _____
Moles ___ Now ___ Past ___ Not Sure _____

Breast

Pain in Breast ___ Now ___ Past ___ Not Sure _____
Nipple Discharge ___ Now ___ Past ___ Not Sure _____
Lumps ___ Now ___ Past ___ Not Sure _____

Musculoskeletal

Muscle Weakness ___ Now ___ Past ___ Not Sure _____
Muscle or Joint Pain ___ Now ___ Past ___ Not Sure _____

Psychiatric

Depression/Frequent Crying ___ Now ___ Past ___ Not Sure _____
Severe Anxiety ___ Now ___ Past ___ Not Sure _____

Endocrine

Hair Loss ___ Now ___ Past ___ Not Sure _____
Heat/Cold Intolerance ___ Now ___ Past ___ Not Sure _____

Abnormal Thirst ___ Now ___ Past ___ Not Sure _____
Hot Flashes ___ Now ___ Past ___ Not Sure _____

Hematologic/Lymphatic

Frequent Bruises ___ Now ___ Past ___ Not Sure _____
Cuts Do Not Stop Bleeding ___ Now ___ Past ___ Not Sure _____
Enlarged Lymph Nodes ___ Now ___ Past ___ Not Sure _____

Form Completed by: ___ Patient ___ Nurse ___ Physician ___ Other

Print Name: _____

Signature of Patient: _____