

# HORMONE EVALUATION

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## MEDICAL STATUS

Age: _____ Weight: _____ Height: _____ Blood Type: _____	<b>General Health:</b> Excellent:    Good:    Fair:    Poor: <b>Energy Level:</b> High _____ Fairly High _____ Low _____	Blood Pressure: _____ <b>Cholesterol level:</b> Total: _____ Date: _____ HDL:        LDL:        Triglycerides:
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**Known Medical Conditions:**

\_\_\_\_\_

\_\_\_\_\_

**Surgeries and Dates:**

\_\_\_\_\_

\_\_\_\_\_

**Current Medications and how long since prescribed:**

\_\_\_\_\_

\_\_\_\_\_

**Drug Allergies:**

\_\_\_\_\_

<b>Family history of Diabetes:</b> Yes: _____ No: _____	<b>Family history of Heart Disease:</b> Yes: _____ No: _____	<b>Family history of Hormonal Cancer:</b> Yes: _____ No: _____
What type of cancer: _____		

Have you had a bone density scan? Yes: _____ No: _____ Date: _____
Results: _____
Physician's Name: _____ Date of last exam: _____

Have you had a mammogram? Yes _____ No _____ Date: _____
Results: _____
OB/GYN'S Name: _____ Date of last exam: _____

Do you take hormones of any kind? _____ If so, list (include birth control pills or natural hormone cream):				
Brand	Type	Milligrams	How often do you use them	How long have you used them

Have you tried other hormones ? _____ If so, list:		
What kind	What dose	How they affected you, how long you used them, and when discontinued:

**GYNECOLOGICAL HISTORY**

Have you had a hysterectomy? Yes: _____ No: _____ If so, when? _____
Reason: _____

Do you have ovaries: Yes \_\_\_\_\_ No \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Results: \_\_\_\_\_

<b>Date of last period:</b> _____
Describe your periods (For example: Are your periods regular? How many days from start of one period to the start of the next one? Number of days of flow. Describe your flow, is it light or heavy?. Any bleeding between periods?):

Do you have a history of vaginal / bladder infections? \_\_\_\_\_

Do you have symptoms of hypoglycemia? (Do you get headaches, dizzy, or irritable if you miss a meal?) \_\_\_\_\_

Do you have PMS symptoms? Yes: \_\_\_ No: \_\_\_

If yes, when do symptoms start and stop:

PMS patients please fill in this section:

PMS - A	PMS - H	PMS - C	PMS - D
___ Nervous tension	___ Weight gain	___ Headache	___ Depression
___ Mood swings	___ Water retention	___ Cravings	___ Forgetfulness
___ Irritability	___ Breast tenderness	___ Heart palpations	___ Crying
___ Anxiety	___ Bloating	___ Fatigue	___ Insomnia

**DIET**

Dietary Restrictions and or food allergies: \_\_\_\_\_

Describe typical meal choices:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Do you get regular exercise? Yes \_\_\_ No \_\_\_ If yes, please describe: \_\_\_\_\_

Stress level: High: \_\_\_\_\_ Moderate: \_\_\_\_\_ None: \_\_\_\_\_

**Current Supplements (include milligrams/dosages):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you understand what bio-identical (natural) hormones are?

Very familiar \_\_\_ Somewhat familiar \_\_\_ Not familiar at all \_\_\_

*Rate applicable symptoms from 1-10 of each category 1 being mild - 10 severe:*

**Estrogens**

Estrogen Deficiency		Estrogen Excess	
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Depressed	<input type="checkbox"/> Mood Swings (PMS)	<input type="checkbox"/> Fibrocystic Breasts
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Tender Breasts	<input type="checkbox"/> Uterine Fibroids
<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Heart Palpation	<input type="checkbox"/> Water Retention	<input type="checkbox"/> Weight Gain in Hips
<input type="checkbox"/> Foggy Thinking	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Nervous	<input type="checkbox"/> Bleeding Changes
<input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Dry Skin/Hair	<input type="checkbox"/> Irritable	<input type="checkbox"/> Headaches
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anxious	<input type="checkbox"/> Heavy Periods
<input type="checkbox"/> Tearful		<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Breast Cancer
		<input type="checkbox"/> Cold Body Temperature	<input type="checkbox"/> Weight Gain/Waist
		<input type="checkbox"/> Elevated Triglycerides	<input type="checkbox"/> Low Libido

### PROGESTERONE DEFICIENCY

<input type="checkbox"/> Candida Infections	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Break-thru Bleeding
<input type="checkbox"/> Fibrocystic Breasts	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fibroids
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Heavy Periods	<input type="checkbox"/> PMS
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stressed Easily	<input type="checkbox"/> Irritability	<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Headaches	<input type="checkbox"/> Water Retention	<input type="checkbox"/> Cramps	<input type="checkbox"/> Hypothyroid

### Androgens (DHEA and Testosterone)

Androgen Deficiency		Androgen Excess	
<input type="checkbox"/> Low Libido	<input type="checkbox"/> Depressed	<input type="checkbox"/> Excessive Facial Hair	<input type="checkbox"/> Oily Skin
<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Excessive Body Hair	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Thinning Pubic Hair	<input type="checkbox"/> Increased Acne	<input type="checkbox"/> Hair Loss (scalp)
<input type="checkbox"/> Aches/Pains/Arthritis	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Nervous, Irritable
<input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Decrease Muscle Mass	<input type="checkbox"/> Elevated triglycerides	
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Thinning Skin		
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Fibromyalgia		

### Cortisol Imbalance

Cortisol Deficiency		Cortisol Excess	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cold Body Temp.	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Sugar Cravings	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Headaches
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Stress
<input type="checkbox"/> Chemical Sensitivity	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Weight Gain/Waist	<input type="checkbox"/> Cold Body Temp.
<input type="checkbox"/> Stress	<input type="checkbox"/> Aches / Pains	<input type="checkbox"/> Loss of Muscle Mass	<input type="checkbox"/> Sugar Cravings
<input type="checkbox"/> low blood sugar		<input type="checkbox"/> Thinning Skin	<input type="checkbox"/> Low Libido
		<input type="checkbox"/> Elevated triglycerides	<input type="checkbox"/> Hair Loss
		<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Increased Facial Hair
		<input type="checkbox"/> Irritable	<input type="checkbox"/> Increased Body Hair
		<input type="checkbox"/> Anxious	<input type="checkbox"/> Acne
		<input type="checkbox"/> Memory Lapse	<input type="checkbox"/> Nervous

### Thyroid Deficiency

<input type="checkbox"/> Tired or Exhausted	<input type="checkbox"/> Difficult to Concentrate	<input type="checkbox"/> Nails Breaking / Brittle	<input type="checkbox"/> Infertility Problems
<input type="checkbox"/> Sad or Depressed	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Aches / Pains	<input type="checkbox"/> Slowed Reflexes
<input type="checkbox"/> Cold Body Temp.	<input type="checkbox"/> Swelling / Puffy Eyes	<input type="checkbox"/> Low Libido	<input type="checkbox"/> Constipation
<input type="checkbox"/> Cold Hands & Feet	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Thick Tongue
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Slow Ankle Reflex
<input type="checkbox"/> Can't Lose Weight	<input type="checkbox"/> Slow Pulse Rate	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Memory Lapse	<input type="checkbox"/> Decreased Sweating	<input type="checkbox"/> Decreased Muscle Mass	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Hair Dry or Brittle		<input type="checkbox"/> Thinning Skin

