www.TestMyHormones.com

Natural Hormone Replacement
Confidential Evaluation for Women

When Completed Fax To 714-572-2277 and our staff will contact you to discuss potential testing/consultation options.

General Information

Name_____ Age_____ Birth Date _____

Address_____

Home Phone_____ Alt. Ph._____

Occupation_____ Work Hrs. per week _____ Retired _____

Living Situation_____ Marital Status _____

How Did You Hear About Natural Hormone Replacement? _____

Do You Understand the Difference Between Natural and Synthetic Hormones? _____

What Are Your Goals For Natural Hormone Replacement? _____

Medical Status

General Health (Circle One): Excellent Good Fair Poor Height_____ Weight _____

List Current Diagnosis or Medical Conditions:

Drug Allergies:

Food Allergies:

Current Medications and Duration of Treatment:

Current Vitamins/Herbs:

Medical Status (Continued)

Labs: Cholesterol _____ Date _____ Blood Pressure _____ Date _____
Blood Glucose _____ Date _____ Thyroid (Circle) High Average Low

Have You Ever Had a Mammogram _____ Date _____ Results _____

Have You Ever Had a Bone Density Scan _____ Date _____ Results _____

Have You Had Your Hormone Levels Measured Recently _____ Date _____ Results _____

_____

_____

Past Medical Conditions: (Circle All That Apply)

Heart Trouble High Blood Pressure Stroke Varicose Veins Diabetes Clotting Defects

Epilepsy Kidney Trouble Fractures Arthritis Colitis Gallbladder Trouble Asthma

Chronic Fatigue Fibromyalgia Eating Disorder Cancer

Health Care Provider _____ Phone # _____

Address _____

Phone Number _____ Years as your Physician _____

Your Insurance Provider _____ ID # _____

Name of Primary Insured _____ Ins. Phone # _____

Dietary and Social Information

Typical Breakfast Foods:

Typical Lunch Foods:

Typical Dinner Foods:

Typical Snack Foods:

Do You Drink Alcoholic Beverages? (Yes/No) If So, What Kinds, How Much, And How Often?

Do You Smoke? (Yes/No) If So, What Kind, How Much, And How Often?

Do You Use Drugs? (Yes/No) If So, What Kind, How Much, And How Often?

Do You Exercise? (Yes/No) If So, What Kind, How Much, And How Often?

Family Medical History

Father (Living/Deceased) Age _____ Medical History:

Mother (Living/Deceased) Age _____ Medical History:

Brother/Sister (Living/Deceased) Age _____ Medical History:

Brother/Sister (Living/Deceased) Age _____ Medical History:

Brother/Sister (Living/Deceased) Age _____ Medical History:

Brother/Sister (Living/Deceased) Age _____ Medical History:

Other Pertinent Family Medical History:

Gynecological History

Age at First Period _____ if you are Menopausal List Date At Last Period _____

Date Of Last Pelvic Exam _____ & Pap Smear _____ Results? _____

Have You Ever Had An Abnormal Pap? _____Treatment? _____

Are You Sexually Active? _____ Are You Trying to Get Pregnant? _____

Current Birth Control Method: _____How Long? _____

Problems with Birth Control? _____

Past Birth Control and Any Related Problems: _____

How Many Days from the Start of One Period to the Start of the Next? _____

Number of Days of Flow _____ Amount of Bleeding _____

Premenstrual Symptoms: _____

Starting and Ending When: _____

Any Current Changes in Your Normal Cycle? _____

Any Bleeding Between Periods: _____ When: _____

Any Pelvic Pain, Pressure, or Fullness? _____ Describe: _____

Any Unusual Vaginal Discharge or Itching? _____ Describe: _____

Treatment: _____

Age at First Pregnancy: _____ How Many Full Term Pregnancies? _____

Do You Experience Any Problems? _____

Any Interrupted Pregnancies? _____

Have You Had A Tubal Legation? _____ When? _____

Have You Had Any Part or Whole Ovary Removed? _____ When? _____

Have You Had a Hysterectomy? _____ When? _____

Do Your Ovaries Remain? _____

List and Explanation of Symptoms

Headaches (P, E): Absent Mild Moderate Severe

Explain: _____

Low Libido (P, D): Absent Mild Moderate Severe

Explain: _____

Anxiety (P, E): Absent Mild Moderate Severe

Explain: _____

Swollen Breast (P, E): Absent Mild Moderate Severe

Explain: _____

Fuzzy Thinking (P): Absent Mild Moderate Severe

Explain: _____

Depression (P, E): Absent Mild Moderate Severe

Explain: _____

Food Cravings (P): Absent Mild Moderate Severe

Explain: _____

Irritability (P): Absent Mild Moderate Severe

Explain: _____

Insomnia (P): Absent Mild Moderate Severe

Explain: _____

Cramps (P): Absent Mild Moderate Severe

Explain: _____

Emotional Swings (P): Absent Mild Moderate Severe

Explain: _____

Painful Breast (P): Absent Mild Moderate Severe

Explain: _____

Weight Gain (P): Absent Mild Moderate Severe

Explain: _____

Bloating (P): Absent Mild Moderate Severe

Explain: _____

Low Concentration (P): Absent Mild Moderate Severe

Explain: _____

Hot Flashes (E): Absent Mild Moderate Severe

Explain: _____

Difficulty Breathing (E); Absent Mild Moderate Severe

Explain: _____

Vaginal Dryness (E): Absent Mild Moderate Severe

Explain: _____

Dry Hair/ Skin (E): Absent Mild Moderate Severe

Explain: _____

Memory Loss (E): Absent Mild Moderate Severe

Explain: _____

Urinary Infections (E): Absent Mild Moderate Severe

Explain: _____

Heart Palpitations (E): Absent Mild Moderate Severe

Explain: _____

Yeast Infections (E): Absent Mild Moderate Severe

Explain: _____

Painful Intercourse (E): Absent Mild Moderate Severe

Explain: _____

No Orgasm (E): Absent Mild Moderate Severe

Explain: _____

Water Retention (D): Absent Mild Moderate Severe

Explain: _____

Fatigue (D): Absent Mild Moderate Severe

Explain: _____

Fibrocystic Breast (D): Absent Mild Moderate Severe

Explain: _____

Heavy Menses (D): Absent Mild Moderate Severe

Explain: _____

Irregular Menses (D): Absent Mild Moderate Severe

Explain: _____

Uterine Fibroids (D): Absent Mild Moderate Severe

Explain: _____

Sweet Cravings (D): Absent Mild Moderate Severe

Explain: _____

Weight Gain (D): Absent Mild Moderate Severe

Explain: _____

Low Thyroid (D) Absent Mild Moderate Severe

Explain: _____