Stuart Ellis Pharmacy
Confidential Hormone Evaluation

General Information

Date: _____

Name: _____ Birthdate: _____ 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):
_____
_____
_____

Current medical conditions:

Please check all that apply

	Heart disease (i.e. CHF)		Depression
	High cholesterol or lipids		Epilepsy
	High blood pressure		Headaches/migraines
	Stroke		Eye Disease (i.e. glaucoma)
	Ulcers (stomach, esophagus)		Osteoporosis
	Hypothyroidism		Cancer
	Hyperthyroidism		Type:
	Hormonal related issues		Fibromyalgia
	Lung disease (i.e. asthma, COPD)		Chronic Fatigue
	Blood clotting problems		Kidney/Bladder problems
	Diabetes		Liver problems
	Arthritis		Eating disorder
	Irritable Bowel Syndrome		Other:

Have you had your cholesterol checked?: _____ Date: _____ Results: _____
Have you had a PAP smear? _____ Date: _____ Results: _____
Have you had a mammogram? _____ Date: _____ Results: _____
Have you had a bone density scan? _____ Date: _____ Results: _____
Have you had your thyroid checked? _____ Date: _____ Results: _____
Bone Size: Small _____ Medium _____ Large _____

Medication History:

Current Prescription Medications			
Name	Strength	Date started	How often per day

Current Over-the-Counter Medications			
Name	Strength	Date Started	How often per day

Current Natural Supplements, Vitamins and Minerals			
Name	Strength	Date Started	How often per day

Hormones Currently or Previously Taken			
Name & Strength	Date started	Date Stopped	Reason

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: _____
Snacks: _____Cravings:_____
Daily Water Intake: _____

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				
Constipation				
Painful intercourse				
Inability to Reach orgasm				
Low Libido				
Irregular Menses				
Water retention				
Uterine fibroids				