CarrDrugs

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CONFIDENTIAL FEMALE HORMONE EVALUATION

Name: _____ **Birthdate**: _____ **Age**: _____

Address: _____
Street City State Zip

Phone: _____ **Email**: _____

Height: _____ **Weight**: _____ **Desired Weight**: _____

What are your goals for taking Hormone Replacement Therapy?
1. _____
2. _____
3. _____

Doctor that we should contact for this therapy:

Name:_____ **Phone**:_____

Address:_____
Street City State Zip

*** Please include a copy of all relevant lab work, especially hormone levels that you have recently obtained.

Questionnaire

Do you use?			**How Often and how much?**
Tobacco?	Yes	No	_____
Alcohol?	Yes	No	_____
Caffeine?	Yes	No	_____
Do you exercise?	Yes	No	_____

Allergies: Please list any allergies and describe the reaction that occurred

Drugs:_____

Foods:_____

Other:_____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements):

_____

_____

_____

_____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include: Heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc).

_____

_____

_____

_____

_____

Current Prescription Medications (including hormones):

	Medication Name and Strength	Date Started	How Often per day
1.			
2.			
3.			
4.			
5.			

List Hormones Previously Taken:

	Date Started	Date Stopped	Reason
1.			
2.			
3.			
4.			
5.			

Have you ever used oral contraceptives (birth control)? Yes No
If you experienced any problems, please describe:
_____
_____

How many pregnancies have you had? _____ **How many children? _____**

Any Interrupted pregnancies? Yes No
If yes, please explain:_____
_____

Have you had a tubal ligation: Yes No **If yes, date of surgery: _____**

Have you had a hysterectomy? Yes No **If yes, date of surgery**: _____
Reason: _____

Do your ovaries remain? Yes No

Do you have a family history of any cancers or osteoporosis? Yes No
Please list the family member(s):
_____
_____
_____

Have you had any of the following tests performed?
Mammography Yes No Date: _____ Outcome:_____
PAP Smear Yes No Date: _____ Outcome:_____
Bone Density Yes No Date: _____ Outcome:_____

What age did your period start? _____
How many days is/was your cycle? *(Example: 28)* _____
Is/was your menstrual flow heavy or light? _____ **Any clots?** Yes No

Have you ever had what YOU would consider to be abnormal cycles? Yes No
Explain:_____
_____
_____
When was your last period? _____ **How many days did it last? _____**

Do you or have you ever suffered from Premenstrual Syndrome (PMS) symptoms? Yes No
Explain:_____
_____

Symptom Checker

Please fill out the following chart according to the severity of your symptoms.
If you are not experiencing a symptom, please mark "Absent."

Symptoms	Absent	Mild	Moderate	Severe
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Incontinence				
Bleeding Changes				
Fibrocystic Breast				
Weight Gain				
Fluid Retention				
Dry Skin/ Hair				
Hair Loss				
Anxiety				
Depression				
Mood Swings				
Irritability				
Headaches				
Breast Tenderness				
Cramps				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Fatigue				
Loss of Memory				
Foggy Thinking				
Acne				
Arthritis				
Decreased Sex Drive				
Harder to Reach Climax				

Any other symptoms and their severity:

_____

_____

_____