Women's Health Evaluation

Date: ___/___/____

I. Patient Information			
Name:		DOB:	Age:
Address:			
City:		State:	ZIP:
Phone:	Email:		
Gender:	Height:	Weight:	

II. Doctor Information	
Name:	Phone:
Address:	

III. Allergies

☐ Penicillin	☐ Morphine	☐ Dye Allergies	☐ Pet Allergies
☐ Codeine	☐ Aspirin	☐ Nitrate Allergy	☐ Seasonal (Pollen)
☐ Sulfa Drug	☐ Food Allergies	☐ Unknown Allergies	☐ Other: _____

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

_____

IV. Medical Conditions/Diseases

☐ Heart disease	☐ Ulcers (stomach, esophagus)	☐ Blood clots	☐ Epilepsy
☐ High cholesterol or lipids	☐ Thyroid disease	☐ Diabetes	☐ Headaches/migraines
☐ High blood pressure	☐ Hormone-related issues	☐ Arthritis or joint issues	☐ Ocular disease
☐ Cancer	☐ Lung conditions	☐ Depression	

☐ Other (please list):

V. Family History

Check all that apply	Family member(s)
☐ Uterine cancer	
☐ Ovarian cancer	
☐ Fibrocystic breast	
☐ Heart disease	
☐ Osteoporosis	
☐ Thyroid disease	

VI. History of pregnancy

Have you ever used oral contraceptives? ☐ Yes ☐ No	If yes, have you had any problems? ☐ Yes ☐ No
If you have had problems, describe them below: _____	
How many pregnancies have you had?	How many children?
Any interrupted pregnancies? ☐ Yes ☐ No	Have you had a hysterectomy? ☐ Yes (Date:_____) ☐ No
Have you had your ovaries removed? ☐ Yes ☐ No	Have you had a tubal ligation? ☐ Yes (Date:_____) ☐ No

VII. Testing/Menstruation

Check those that apply and note the date of the latest test:

Mammography ☐ Yes (Date:_____) ☐ No	PAP Smear ☐ Yes (Date:_____) ☐ No
When was your last period?	How many days did it last?

Do you have or did you ever have Premenstrual Syndrome (PMS)? ☐ Yes ☐ No

Since you first began having periods, have you ever had what you consider to be abnormal cycles?
☐ Yes (Date:_____) ☐ No

If yes, explain (symptoms, age, etc.):

_____

_____

_____

VIII. Goals

What are your symptoms and chief complaints you'd like resolved?

_____

_____

List your goals for taking bHRT:

_____

_____

IX. Referral

Where did you receive information about bio-identical hormone restoration therapy?

☐ Doctor
☐ Friend/family member
☐ Book (list title and author: _____)
☐ Other: _____

Patient Name: _____

X. Prescription Medications

Medication name	Strength	Times per day	Start Date

XI. Hormones

Hormones previously taken:	Start Date	End Date	Reason for stopping

XII. OTC Medications

Check all products you use regularly or occasionally:

Pain relievers:
- ☐ Aspirin
- ☐ Acetaminophen

Anti-inflammatory:
- ☐ Ibuprofen
- ☐ Naproxen

Combination cold products:
- ☐ Cough suppressant
- ☐ Decongestant
- ☐ Antihistamine

Other:
- ☐ Sleep aids
- ☐ Antacids
- ☐ Antidiarrheals
- ☐ Acid blockers
- ☐ Laxatives/stool stofteners
- ☐ Diet aids/weight-loss products
- ☐ Other: _____

XIII. Supplements

Check all products you are currently using:

- ☐ Vitamins (examples: multiple or single vitamins like B complex, E, C, beta carotene)
- ☐ Minerals (examples: calcium, magnesium, chromium, etc.)
- ☐ Herbs (examples: ginseng, Ginkgo biloba, echinacea, herbal/medicinal teas, tinctures, remedies, etc.)
- ☐ Enzymes (examples: digestive formulas, papaya, bromelain)
- ☐ Nutrition/protein supplements (examples: protein powders, amino acids, fish oils, etc.)
- ☐ Other: _____

XIV. Lifestyle

List use of:			Qty.	Daily	Weekly	Monthly	Occasionally
Tobacco	☐ No	☐ Yes	_____	☐	☐	☐	☐
Alcohol	☐ No	☐ Yes	_____	☐	☐	☐	☐
Caffeine	☐ No	☐ Yes	_____	☐	☐	☐	☐

Occupation: _____ Level of Stress: ☐ Mild ☐ Moderate ☐ Severe

Patient Name: _____

Hormone Replacement Therapy Patient Information Sheet

	Absent	Mild	Moderate	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	❑	❑	❑	❑
Difficulty climaxing	❑	❑	❑	❑
Decreased sex drive	❑	❑	❑	❑
Hair loss	❑	❑	❑	❑

Patient Name: _____

List any questions you have about bio-identical hormone restoration therapy:

For Physicians Only
In conjunction with any available labs, fax completed health form to **(866) 635-2329.**

Please check whether:
❑ A pharmacist should call the patient for follow up and formulate their dose.
OR
❑ The form is just for our records.

Patient Name: _____