Hormone Assessment Patient Information Sheet

Date______ Patient's Name___________________ Phone_______ Cell_______ DOB:_____

Address:_________________________________City____________St________zip________

Doctors Name _____________Phone __________FAX___________ Insurance #__________

Please answer all the questions below

Have you had a hysterectomy? Yes____ No____ Date _____ when was your last period ______
Have you been on hormone replacement since your hysterectomy? Yes___ No___ (___________)
Do you have Fibromyalgia Yes___No___ or Fibrocystic breast Yes___No___
Are you being treated for depression______if so what are you taking______________________
How much caffeine do you drink? coffee_____tea_____coke_____ a day. Water____ Ht___Wt____
Have you had children? Yes____ No ____ Are you a smoker? Yes____ No ____How Many____
What medication are you taking: ____
____
What vitamin supplements are you taking?____
____
How many days do you exercise a week? 1-2-3-4-5-6-7 what do you do_____________________

Is there a family history of any cancer and who?
Uterine Cancer______ Who______________
Ovarian Cancer ______Who______________
Breast Cancer ______ Who ______________
Osteoporosis _______ Who ______________
Heart Disease _______ Who______________
High blood pressure_______who__________

Have you experienced any of the following symptoms recently?

Symptoms	Yes	No	Symptoms	Yes	No
Sleep disruption			**Fatigue**		
Short Term Memory loss			**Weight gain**		
Depression			**Decreased sex drive**		
Irritability			**Harder to reach climax**		
Nervousness			**Vaginal dryness**		
Headaches			**Joint pain**		
Hot flashes			**Breast Tenderness**		
Night Sweats			**Bladder symptoms**		
Dry skin			**Hair loss**		
Arthritis			**Leg pain**		

Do you have any questions for me or comments you would like to share?

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