bHRT Health Evaluation

Today's Date: _____

Name: _____ **Birth date:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **E-mail Address:** _____

Gender: □ Male □ Female **Height:** _____ **Weight:** _____

Doctor's Name: **Address:** **Phone:**

_____

_____

_____

Allergies: Please check all that apply.

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

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

_____

_____

_____

Medical Conditions/Diseases: Please check all that apply to you.

___ Heart Disease
___ High Cholesterol or Lipids
___ High Blood Pressure
___ Cancer
___ Ulcers (Stomach, Esophagus)
___ Thyroid Disease
___ Hormonal Related Issues
___ Lung Condition (Ex. Asthma, Emphysema, COPD)
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or Joint Problems
___ Depression
___ Epilepsy
___ Headaches/Migraines
___ Eye Disease

___ Other: _____

Do you have a family history of any of the following?

Uterine Cancer _____ Family Member(s) _____
Ovarian Cancer _____ Family Member(s) _____
Fibrocystic Breast _____ Family Member(s) _____
Breast Cancer _____ Family Member(s) _____
Heart Disease _____ Family Member(s) _____
Osteoporosis _____ Family Member(s) _____
Thyroid Disease _____ Family Member(s) _____

Have you ever used oral contraceptives?: □ No □ Yes
Any problems? □ No □ Yes
If YES, describe and problem(s).

_____
_____

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

Any interrupted pregnancies? □ No □ Yes

Have you had a hysterectomy? □ No □ Yes (date) _____
Ovaries Removed? □ No □ Yes

Have you had a tubal ligation? □ No □ Yes (date) _____

Have you had any of the following tested performed? Check those that apply and note date of last test.

Mammography □ No □ Yes Date: _____
PAP Smear □ No □ Yes Date: _____

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

If YES, please explain (such as age when this occurred, symptoms):

_____
_____
_____
_____

Where did you receive the information to consider Bio-identical Hormone restoration Therapy?

□ Doctor □ Friend/Family Member □ Book□ Other: _____

If by book, please list name and author of book: _____

What are you goals with taking BHRT?

_____
_____
_____
_____
_____
_____
_____
_____

Patient Name: _____

Current Prescription Medications:

Medication Name	Strength	Date Started	Times Per Day

List Hormones previously taken:

	Date Started	Date Stopped	Reason Stopped

Over –the-counter medications:

Please check all products that you use regularly or occasionally.

Pain Relievers:
___ Aspirin
___ Acetaminophen

Anti-inflammatory:
___ Ibuprofen
___ Naproxen

Combination Cold Products:
___ Cough Suppressant
___ Antihistamine Product
___ Decongestant Product

Other:
___ Sleep Aids
___ Antidiarrheals
___ Laxatives/Stool Softeners
___ Diet Aids/Weight Loss Products
___ Antacids
___ Acid Blockers
___ Others
_____
_____

Supplements: Please identify and list the products you are using.

□ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
□ Minerals (examples: calcium, magnesium, chromium, etc.)
□ Herbs (examples: Ginseng, Ginko 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.)
□ Others:
_____
_____

List Use of:			Qty	Daily	Weekly	Monthly	Occasionally
Tobacco	□ No	□ Yes	_____	□	□	□	□
Alcohol	□ No	□ Yes	_____	□	□	□	□
Caffeine	□ No	□ Yes	_____	□	□	□	□

When was your last period? _____

How many days did it last? _____

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

Patient Name: _____

Please list any questions you have about Bio-identical Hormone Restoration Therapy.

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	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____

Patient Name: _____