# PCCA CONFIDENTIAL HORMONE EVALUATION

## MEDICAL HISTORY

**Today's Date:** _____

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

**Address:** _____

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

**Phone:** _____ **E-Mail Address:** _____

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

How often and how much?

Do you use tobacco? ☐ Yes ☐ No _____
Do you use alcohol? ☐ Yes ☐ No _____
Do you use caffeine? ☐ Yes ☐ No _____

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

**Allergies:** Please check all that apply.

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ seasonal (pollen) allergies
___ sulfa drug ___ food allergies ___ no known allergies other: _____

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

**Over-the-counter (OTC) issues:**

Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever
___ Aspirin
___ Acetaminophen (example: Tylenol®)
___ Ibuprofen (example: Motrin IB®)
___ Naproxen (example: Aleve®)
___ Ketoprofen (example: Orudis KT®)
___ Cough suppressant (example: Robitussin DM®)
___ Antihistamine product (example: Chlor-Trimeton®)
___ Decongestant product (example: Sudafed ®)
___ Combination product (cough+cold reliever)(example: Triaminic DM®)
___ Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
___ Antidiarrheals (examples:Imodium®, Pepto Bismol®, Kaopectate®)
___ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
___ Diet aids/weight loss products (example: Dexatril®)
___ Antacids (examples: Maalox®, Mylanta®)
___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Other (please list)
_____

**PATIENT NAME:** _____

___ **Nutritional/Natural 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, colloidal minerals, various single minerals)
☐ herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
☐ enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
☐ nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)
☐ others (glucosamine, etc.)

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

___ Heart disease (example: Congestive Heart Failure)
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ High blood pressure (example: Hypertension)
___ Cancer
___ Ulcers (stomach, esophagus)
___ Thyroid disease
___ Hormonal Related Issues
___ Lung condition (example: asthma, emphysema, COPD)
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression
___ Epilepsy
___ Headaches/migraines
___ Eye Disease (glaucoma, etc.)
___ Other: Please list: _____

**Current Prescription Medications:**

| Medication Name | Strength | Date Started | How often per day. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**List Hormones previously taken.** Date Started Date Stopped Reason

_____
_____
_____
_____

Bone Size _____ Small _____ Medium _____ Large _____

Body Type: ☐ Androgenic ☐ Estrogenic

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

_____
_____

**PATIENT NAME:** _____

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

Any interrupted pregnancies? ☐ No ☐ Yes

Have you had a hysterectomy? ☐ No ☐ Yes (Date of Surgery) _____
Ovaries removed? ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes (Date) _____

**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) | _____ |

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**Have you had any of the following tests 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….):

_____
_____
_____
_____
_____

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ☐ No ☐ Yes
If YES, explain symptoms:

_____
_____
_____

**PATIENT NAME:** _____

**How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?**

Doctor ☐ ☐ Self ☐ Friend/Family Member ☐ Other

**What are your goals with taking BHRT?**

_____
_____
_____
_____

**Please write down any questions you have about Bio-Identical Hormone Replacement Therapy.**

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**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:** _____