Your Health Information.

BHRT FEMALE PATIENT INFORMATION

NAME: _________________________________**DATE**______________________

EMAIL ADDRESS: ____

PHONE NUMBER: CELL:_________________**HOME:**______________________

DATE OF BIRTH ______/______/______ **AGE:** ___________________________

HEIGHT___________**WEIGHT** ___________ **BMI**______________

Who referred you to us? ____

Please list your health care provider information and the date of your last visit:
DOCTOR'S NAME: ________________________________ PHONE: __________________________
Address: _____________________________________City:___________ State:______ Zip:________
Date of Last Visit: _________________________

SOCIAL HISTORY

ALCOHOL: o**Y** o**N** How much per week? ______________
DO YOU SMOKE? o**Y** o**N** If yes, how many packs per day? ___________
DO YOU EXERCISE? o**Y** o**N** If yes, what type? _____________ How often? ______________
CAFFEINE CONSUMPTION o**Y** o**N** Type (coffee, soda) ___________ How much? _________
DESCRIBE YOUR DIET: ____
____
____

HEALTH SUMMARY FORM

Allergies to medication? oY oN ___________________________________

Prescription or OTC Medication? oY oN

Medication Name Date started
____
____
____
____

List Hormones Previously Taken (Synthetic, Bio-Identical and over-the-counter)**:**

Date started Date stopped Reason
____
____
____

Current or Past Medical Conditions: (Please check all that apply)

o High Cholesterol
o High Blood Pressure
o Cancer (type: _______________)
o Asthma
o Blood Clotting Disorder
o Diabetes (type: ______________)
o Epilepsy
o Osteoporosis/Osteopenia
o Other: ______________________
o Heart Disease
o Thyroid Disorder
o Kidney Disorder
o Arthritis
o Liver Disorder
o Depression
o Headaches/Migraine
o Chronic Fatigue Syndrome

Family History: (Please check all that apply)

o Breast Cancer - Family Member(s) ____
o Cervical Cancer - Family Member(s) ____
o Ovarian Cancer - Family Member(s) ____
o Heart Disease - Family Member(s) ____

Gyn History:

Last menstrual cycle? ____
Heavy Bleeding? ____
Irregular Bleeding?____
Start of Menopause?____
On Birth Control Medication or Hormone Replacement currently?
____

Have you had any of the following tests performed?
Mammography o Y o N Date: ____
Pap Smear o Y o N Date: ____

Surgical History:

Ovary (Ovaries) removed ? o Y o N Date:____
Hysterectomy? o Y o N Date:____
____
____
____

Why would you like to start Bio-Identical Hormone Replacement Therapy?

SYMPTOM SHEET

(Please check all that apply)

	Absent	Mild	Moderate	Severe
Fibrocystic Breast	___________	__________	____________	__________
Heavy/Irregular menses	___________	__________	____________	__________
Hot Flashes	___________	__________	____________	__________
Night Sweats	___________	__________	____________	__________
Vaginal Dryness	___________	__________	____________	__________
Breast Tenderness	___________	__________	____________	__________
Menstrual Cramps	___________	__________	____________	__________
Headaches	___________	__________	____________	__________
Fluid Retention	___________	__________	____________	__________
Irritability	___________	__________	____________	__________
Mood Swings	___________	__________	____________	__________
Anxiety	___________	__________	____________	__________
Depression	___________	__________	____________	__________
Sleep Disturbances/Insomnia	___________	__________	____________	__________
Dry Skin/Hair	___________	__________	____________	__________
Bladder Symptoms	___________	__________	____________	__________
Hair Loss	___________	__________	____________	__________
Fatigue	___________	__________	____________	__________
Weight Gain	___________	__________	____________	__________
Loss of Memory	___________	__________	____________	__________
Arthritis	___________	__________	____________	__________
Decreased Sex Drive	___________	__________	____________	__________
Harder to Reach Climax	___________	__________	____________	__________