

**CONFIDENTIAL MEDICAL HISTORY**

Today's Date: \_\_\_\_\_

**Patient information**

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Gender: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

How often and how much?

Do you smoke? Yes No \_\_\_\_\_

Do you use alcohol? Yes No \_\_\_\_\_

Do you use caffeine? Yes No \_\_\_\_\_

**Doctor's Name:**

Address:

Phone:

Allergies: Yes No \_\_\_\_\_

If yes, please describe the allergic reaction you experienced and when it occurred?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_ **Nutritional/Natural Supplements:** Please list the products you are using:


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

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

**Current Prescription Medications:**

Medication Name	Strength	Date Started	How often per day
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Hormones previously taken.	Date Started	Date Stopped	Reason
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Bone Size \_\_\_\_\_ Small \_\_\_\_\_ Medium \_\_\_\_\_ Large \_\_\_\_\_

Have you ever used oral contraceptives? No Yes

Any problems with them? No Yes

If YES, describe any problem(s).

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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) \_\_\_\_\_

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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CLINICAL HORMONE PROFILE**

	ABSENT	MILD	MODERATE	SEVERE
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Headaches/Migraine	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Heavy/Irregular menses	_____	_____	_____	_____
Breakthrough bleeding	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Sleep Disturbances/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Short-term memory loss	_____	_____	_____	_____
Stress incontinence	_____	_____	_____	_____
Arthritic pain	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Food cravings	_____	_____	_____	_____
Inability to concentrate	_____	_____	_____	_____

Patient Name: \_\_\_\_\_

