CONFIDENTIAL FEMALE HORMONE EVALUATION

Please email completed form to JODY@SPRUCEWOODPHARMACY.COM
MUST BE COMPLETED PRIOR TO CONFIRMED APPOINTMENT

Today's Date: _____

Name: _____ Birthdate: _____ Age:

Address:_____ _____
Street City State Zip

Phone: _____ Email:_____

Height: _____ Weight: _____ Desired Weight: _____

Occupation: _____ Hobbies: _____

			How often and how much?
Do you use tobacco?	☐ Yes	☐ No	_____
Do you use CBD or THC?	☐ Yes	☐ No	_____
Do you use alcohol?	☐ Yes	☐ No	_____
Do you use caffeine?	☐ Yes	☐ No	_____
Do you exercise?	☐ Yes	☐ No	_____
How long have you been exercising? (months/years)			_____
Type of exercise preferred?			_____

Typical # of hours of sleep per night: _____ Normal bedtime: _____

Uninterrupted? ☐ Yes ☐ No Time and reason for interruption: _____

Do you wake rested or tired (even when getting 7-8 hours of sleep)? _____

Are you or have you ever been a night shift worker? ☐ Yes ☐ No

If yes, please describe when and for how long: _____

What would you like to change about your current dietary choices?

_____

_____

Patient Name: _____

Allergies: Please list any allergies and describe the reaction that occurred.
Drugs: _____
Foods: _____
Other: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements): _____
_____
_____
_____
_____
_____

Medical Conditions/Diseases: Please list any conditions/diseases that you have been diagnosed with or suffer from. (Examples include heart disease, high blood pressure, depression, ulcers, arthritis, insomnia, etc.).
_____
_____
_____

Current Prescription Medications (including hormones):

Medication Name and Strength	Date Started	How Often per Day	Medical Condition Being Treated

List Hormones Previously Taken:

	Date Started	Date Stopped	Reason

Have you ever used oral contraceptives (birth control)? ☐ Yes ☐ No
If you experienced any problems, please describe:
_____
_____

Patient Name: _____

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

Have you had any interrupted pregnancies? ☐ Yes ☐ No

If you have been pregnant, how did you feel while pregnant? Please explain (ex: great, horrible, to be expected) _____

Have you had a tubal ligation? ☐ Yes ☐ No If yes, date of surgery: _____

Have you had a hysterectomy? ☐ Yes ☐ No If yes, date of surgery: _____

Reason for hysterectomy/diagnosis: _____

Do your ovaries remain? ☐ Yes ☐ No

Have you had an endometrial ablation? ☐ Yes ☐ No If yes, date of surgery: _____

Family history of Breast Cancer? ☐ Yes ☐ No Family Member: _____

Family history of Uterine Cancer? ☐ Yes ☐ No Family Member: _____

Family history of Ovarian Cancer? ☐ Yes ☐ No Family Member: _____

Do you have a family history of any cancers or osteoporosis? Please list the family member(s):

_____

_____

_____

Have you had any of the following tests performed?

Mammography	☐ Yes	☐ No	Date: _____	Outcome: _____
PAP smear	☐ Yes	☐ No	Date: _____	Outcome: _____
Bone density	☐ Yes	☐ No	Date: _____	Outcome: _____

What age did your period start? _____ How many days is/was your cycle (Example: 28): _____

Is/was your menstrual flow heavy or light? _____ Any clots? ☐ Yes ☐ No

At what age (if known) did your mother, maternal aunts, and/or sisters go through menopause?

_____

Have you ever had what YOU would consider to be abnormal cycles? ☐ Yes ☐ No If yes, explain:

_____

_____

_____

When was your last period? _____ How many days did it last? _____

Have you ever experienced Premenstrual Syndrome (PMS) symptoms? ☐ Yes ☐ No If yes, explain:

_____

_____

_____

Patient Name: _____

Hot Flashes

# of times/day AM_____ Mid-Day_____ PM_____ All Day_____

Intensity of each time of day (label each time of day as mild, moderate or severe):

	None	Mild	Moderate	Severe
Night Sweats	☐	☐	☐	☐
Describe	_____			
Vaginal Dryness	☐	☐	☐	☐
Describe	_____			
Incontinence	☐	☐	☐	☐
Describe	_____			
Bleeding Changes	☐	☐	☐	☐
Describe	_____			
Fibrocystic Breast	☐	☐	☐	☐
Describe	_____			
Weight Gain	☐	☐	☐	☐
Describe	_____			
Fluid Retention	☐	☐	☐	☐
Describe	_____			
Dry Skin/Hair	☐	☐	☐	☐
Describe	_____			
Hair Loss	☐	☐	☐	☐
Describe	_____			
Anxiety	☐	☐	☐	☐
Describe	_____			
Depression	☐	☐	☐	☐
Describe	_____			
Mood Swings	☐	☐	☐	☐
Describe	_____			
Bowel Movements	☐	☐	☐	☐
Describe	_____			

Patient Name: _____

	None	Mild	Moderate	Severe
Irritability	☐	☐	☐	☐
Describe	_____			
Headaches	☐	☐	☐	☐
Describe	_____			
Breast Tenderness	☐	☐	☐	☐
Describe	_____			
Cramps	☐	☐	☐	☐
Describe	_____			
Difficulty Falling Asleep	☐	☐	☐	☐
Describe	_____			
Difficulty Staying Asleep	☐	☐	☐	☐
Describe	_____			
Fatigue	☐	☐	☐	☐
Describe	_____			
Memory Loss	☐	☐	☐	☐
Describe	_____			
"Foggy" Thinking	☐	☐	☐	☐
Describe	_____			
Acne	☐	☐	☐	☐
Describe	_____			
Arthritis	☐	☐	☐	☐
Describe	_____			
Decreased Sex Drive	☐	☐	☐	☐
Describe	_____			
Difficulty Reaching Orgasm	☐	☐	☐	☐
Describe	_____			
Stress	☐	☐	☐	☐
Describe	_____			
Sugar Cravings	☐	☐	☐	☐
Describe	_____			

Patient Name: _____

	None	Mild	Moderate	Severe
Excess Facial/Body Hair	☐	☐	☐	☐

Describe _____

Other Symptoms:

_____

_____

_____

What are your goals for taking Hormone Replacement Therapy?

1. _____
2. _____
3. _____

Doctor to contact for this therapy:

Name:_____Phone: _____

Address:_____

Street City State/Province Zip

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