Integrative Hormone Consulting

7720 Rivers Edge Dr., Suite 121
Columbus, OH 43235
Ph: 614-888-8923
Fax: 614-888-8931
www.IntegrativeHormoneConsulting.com

Confidential Female Medical History Form

Today's Date: _____

Date of Consult: _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ Work: _____ Email: _____

Best Time to Call: _____

Occupation: _____ Full Time: ___ Part Time: ___ Retired: ___ Unemployed: ___ Other: ___

Living Situation: Spouse: ___ Alone: ___ Partner: ___ Friend(s): ___ Parents: ___ Children: ___ Other: ___

Marriage Status: Married: ___ Single: ___ Divorced: ___ Widowed: ___

Height: _____ Weight: _____ BMI: _____

Pets: _____

How did you arrive at the decision to consider Bioidentical Hormone Replacement Therapy?

Doctor: _____ Self: _____ Family Member/ Friend: _____ Other: _____

What are your goals for taking BHRT?

_____

_____

Doctor's Name: Address: Phone:

_____

_____

_____

_____

_____

_____

Allergies: Please check all that apply:

_____ Penicillin _____ Morphine _____ Dye Allergies

_____ Codeine _____ Aspirin _____ Nitrate Allergies

_____ Sulfa Drug _____ Food Allergies _____ No Known Allergies

_____ Pet Allergies _____ Seasonal (Pollen) _____ Other

Please describe the allergic reaction you experienced when it occurred:

_____

_____

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

_____ Heart Disease (ex. Congestive Heart Failure) _____ High Blood Pressure (ex. Hypertension)

_____ Lung Condition (ex. Asthma, Emphysema, COPD) _____ High Cholesterol or Lipids (ex. Hyperlipidemia)

_____ Diabetes _____ Arthritis or Joint Problems

_____ Cancer _____ Depression

_____ Ulcers (stomach, esophagus) _____ Epilepsy

_____ Thyroid Disease _____ Headaches/ Migraines

_____ Hormonal Related Issues _____ Eye Disease (Glaucoma, etc.)

_____ Blood Clotting Problems _____ Other

If other, please list: _____

Current Prescription Medications:

Medication Name: Strength: Date Started: How often per day:

_____

_____

_____

_____

List hormones previously taken: Date Started: Date Stopped: Reason:

_____

_____

_____

Over the Counter (OTC) Issues: Please check all products that you use occasionally or regularly.

_____ Pain Reliever

_____ Aspirin

_____ Acetaminophen (ex. Tylenol®)

_____ Ibuprofen (ex. Motrin IB®)

_____ Naproxen (ex. Aleve®)

_____ Ketoprofen (ex. Orudis KT®)

_____ Cough Suppressant (ex. Robitussin DM®)

_____ Antihistamine product (ex. Chlor- Trimeton®)

_____ Decongestant product (ex. Sudafed®)

_____ Combination cough +cold reliever (ex. Triaminic®)

_____ Sleep aids (ex. Excedrin PM®, Unisom®, Sominex®)

_____ Antidiarrheals (ex. Imodium®, PeptoBismol®, Kaopectate®)

_____ Laxatives/ Stool Softeners (ex. Doxidan®, Correctol®)

_____ Diet Aids/ Weight loss products (ex. Dexatrim®)

_____ Antacids (ex. Maalox®, Mylanta®)

_____ Acid Blockers (ex. Tagamet HB®, Pepcid AC®, Zantac 75®)

_____ Others

If others, please list: _____

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

_____ Vitamins (ex. Multiple or single vitamins such as B complex, E, C, Beta Carotene)

_____ Minerals (ex. Calcium, magnesium, chromium, colloidal minerals, various single minerals)

_____ Herbs (ex. Ginseng, Gingko Biloba, Echinacea, other herbal medicinal tests, tinctures, remedies, etc.)

_____ Enzymes (ex. Digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)

_____ Nutritional/ protein supplements (ex. Shark cartilage, protein powders, amino acids, fish oil, etc.)

_____ Others (ex. Glucosamine, etc.)

Have you had any of the following tests performed? Please check those that apply and note the date of the last test.

Mammography No: _____ Yes: _____ Date: _____ Results: _____

Cholesterol Level No: _____ Yes: _____ Date: _____ Results: _____

Bone Density No: _____ Yes: _____ Date: _____ Results: _____

Do you use tobacco? No: _____ Yes: _____ How often/ How much? _____

Do you use alcohol? No: _____ Yes: _____ How often/ How much? _____

Do you use caffeine? No: _____ Yes: _____ How often/ How much? _____

Do you get routine physical exercise? No: _____ Yes: _____ What type? _____

Meal Choices:

Breakfast: _____

Lunch: _____

Dinner: _____

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): _____

Gynecological History

Age at first period: _____ Date of last period: _____

Date of last pelvic exam: _____ Date of last PAP smear: _____ Results: _____

Have you ever had an abnormal PAP? _____ Treatment: _____

Are you sexually active? _____ Are you trying to get pregnant? _____

Current Birth Control Method: _____ How long? _____

Any Problem with Birth Control Method: _____ How long? _____

Past birth control and any related problems: _____

How many days from start of one period to the start of next: _____

Number of days flow: _____ Amount of bleeding: _____ Amount of cramps: _____

Premenstrual symptoms: _____

Starting and ending when: _____

Any current changes in your normal cycle: _____

Are you bleeding between periods? _____ When: _____

Any pelvic pain, pressure or fullness? _____ Describe: _____

Any unusual vaginal discharge or itching? _____ Describe: _____

Treatment: _____

Age at first pregnancy: _____ How many full term pregnancies? _____

Problems with pregnancies: _____

_____

Any interrupted pregnancies (miscarriages or abortions)? _____

Have you had a tubal ligation? _____ When: _____

Have you had any part or a whole ovary removed? _____ When: _____

Have you had a hysterectomy? _____ When: _____

Do your ovaries remain? _____

 Last Name: _____

Have you experienced any of the following symptoms recently? Please circle the number that best describes your experiences with 1 being Extremely Mild and 4 being Extremely Severe.

Hormone Replacement Therapy Patient Information Sheet

Sleep Disruptions	1	2	3	4	Fluid Retention	1	2	3	4
Fatigue	1	2	3	4	Headaches	1	2	3	4
Vaginal Dryness	1	2	3	4	Night Sweats	1	2	3	4
Irritability	1	2	3	4	Hair Loss	1	2	3	4
Nervousness	1	2	3	4	Harder to Reach Climax	1	2	3	4
Breast Tenderness	1	2	3	4	Bladder Symptoms	1	2	3	4
Fibrocystic Breasts	1	2	3	4	Foggy Thinking	1	2	3	4
Hot Flashes	1	2	3	4	Heart Palpitations	1	2	3	4
Mood Swings	1	2	3	4	Bone Loss	1	2	3	4
Arthritis	1	2	3	4	Anxiety	1	2	3	4
Loss of Recent Memory	1	2	3	4	Uterine Fibroids	1	2	3	4
Weight Gain	1	2	3	4	Increased Hair Loss (Scalp)	1	2	3	4
Decreased Sex Drive	1	2	3	4	Acne	1	2	3	4
Depression	1	2	3	4	Sugar Craving	1	2	3	4

Thyroid Deficiency

Tired or Exhausted	1	2	3	4	Hair Loss	1	2	3	4
Sad or Depressed	1	2	3	4	Nails Breaking or Brittle	1	2	3	4
Cold Body Temperature	1	2	3	4	Aches/Pains	1	2	3	4
Cold Hands and Feet	1	2	3	4	Low Libido	1	2	3	4
Weight Gain	1	2	3	4	Heart Palpitations	1	2	3	4
Can’t Lose Weight	1	2	3	4	Sleep Disturbances	1	2	3	4
Memory Lapse	1	2	3	4	Bone Loss	1	2	3	4
Forgetful	1	2	3	4	Decreased Muscle Mass	1	2	3	4
High Cholesterol	1	2	3	4	Thinning Skin	1	2	3	4
Difficult to Concentrate	1	2	3	4	Infertility Problems	1	2	3	4
Mood Changes	1	2	3	4	Slowed Reflexes	1	2	3	4
Swelling/Puffy Eyes/Face	1	2	3	4	Constipation	1	2	3	4
Low Blood Pressure	1	2	3	4	Thick Tongue	1	2	3	4
Slow Pulse Rate	1	2	3	4	Slow Ankle Reflex	1	2	3	4
Decreased Sweating	1	2	3	4	Hoarseness	1	2	3	4
Hair Dry or Brittle	1	2	3	4					