Female Hormone Assessment Form

Name:____

Date of Birth:__________________ social security #:_________________________

Street Address: ____

City:______________________________State:_________zip:_________________

Email address:____

In case of emergency, whom should we notify? _______________________________

Phone number(s): ____

Past Medical History

Do you have any medical problems? (i.e. high blood pressure, diabetes, cholesterol, anemia)

____

____

____

____

____

List all surgeries including gyn procedures:___________________________________

____

Name:____ **Date of Birth:**________________

Last pap smear? _______________ Last mammogram?________________ Were either of

these abnormal?_____ If yes, how so?____

____

Do you have any drug allergies?____

Please list medicines that you are currently taking including doses and over the counter meds. ____

____

____

____

Do you smoke? ___yes ___no If yes, then how much daily?____ How many years?____

Are you: __married ___single ___divorced ___significant other?

Family History (medical problems of your siblings, parents, grandparents)_____________

____

____

Please circle if you are experiencing any of the following.

Mood changes	bloating	Sleep loss	Joint pain
Memory loss	Decreased sex drive	Vaginal dryness	Migraine/headache
tension	Weight gain	Hot flashes	fatigue
depression	Breast tenderness	Night sweats	Mental confusion

The information that I supplied is true to the best of my knowledge.

____

Signature Date