HORMONE EVALUATION-**Female** See: Hormone Symptom Survey

-Regular Menses ☐ No
☐ Yes Date of last period_____

-Abnormal Menses ☐ No
☐ Yes Explain_____
_____
_____

-Premenstrual Syndrome ☐ No
☐ Yes List Symptoms _____
_____
_____

Number of Pregnancies _____ Number of Living Births _____
Interrupted Pregnancies ☐ No
☐ Yes Miscarriages _____
Surgical Abortions _____

Have you had:

Mammogram	☐ No ☐ Yes	Date _____ ☐ Abnormal
Thermogram	☐ No ☐ Yes	Date _____ ☐ Abnormal
Breast Biopsy	☐ No ☐ Yes	Date _____ ☐ Abnormal
Mastectomy	☐ No ☐ Yes	Date _____
Tubal Ligation	☐ No ☐ Yes	Date _____
Endometriosis	☐ No ☐ Yes	Surgery ☐ No ☐ Yes
☐ Ablation/Leep	Date _____	
Ovaries Removed	☐ No ☐ Yes	Date _____ Reason_____
Cervical	☐ Biopsy	☐ Cryo ☐ Cone Biopsy Date_____
Hysterectomy	☐ No ☐ Yes	☐ Uterus ONLY ☐ Uterus and Cervix ☐ Uterus, Cervix and Ovaries
Bone Densitometry	☐ No ☐ Yes	Date _____

Current Prescription Medications
Medication Name / Strength / Start Date / Doses/day
_____
_____
_____

Current OTC Hormone Related Products
(i.e. soy, Chinese Angelica, chaste berry etc)
_____
_____
_____

Previous Prescriptions Medications
Medication Name / Stop Date / Reason Stopped
_____
_____
_____

Other Hormone Problems:
☐ Thyroid ☐ Underactive ☐ Overactive ☐ Cancer
☐ Growth Hormone
☐ Parathyroid Hormone
☐ Osteoporosis ☐ Osteopenia

Do you have family history of:
☐ Fibrocystic Breast Disease Family Member(s) _____
☐ Breast Cancer Family Member(s) _____
☐ Uterine Cancer Family Member(s) _____
☐ Ovarian Cancer Family Member(s) _____
☐ Osteoporosis Family Member(s) _____
☐ Alzheimer's Dementia Family Member(s) _____

Name_____ **Date**_____