# Female Hormone Assessment Form

**Name**_____ **DOB**_____ **Date**_____

**Address**_____ **City**_____ **St**_____ **Zip**_____

**Home** (___)___-_____ **Cell** (___)___-_____ **Work** (___)___-_____

**Who should we contact in case of an emergency?** _____ #_____

**How did you hear about MD Transformations?**

- o Newpaper
- o Magazine
- o Money Pages
- o Sun and Surf
- o Internet
- o Brochure
- o Word of Mouth
- o Friend or family (name) _____
- o MD Transformations
- o Radio Station

**Please check the following symptoms you are experiencing:**

- o Hot Flashes
- o Night sweats
- o Moodiness
- o Vaginal dryness
- o Depression
- o Sleepless nights
- o Loss of energy
- o Loss of libido
- o Weight gain
- o Poor cognitive function

If you have any other comments please explain

_____

**Date of last exam:**

- o Pap Smear ___/___/___ Good report ___yes ___no
- o Mammogram ___/___/___ Good report ___yes ___no

**Date of surgery:**

- o Total Hysterectomy ___/___/___ reason _____
- o Oophorectomy ___/___/___ reason _____
- o Breast cancer ___/___/___ are you 5 years out of surgery ___yes ___no

**Family History- has anyone on your mother's side of the family ever had the following**

- o Breast cancer ___yes ___no Who _____
- o Ovarian cancer ___yes ___no Who _____
- o Osteoporosis ___yes ___no Who _____
- o Diabetes ___yes ___no Who _____

**Weight** _____ **Height** _____

# PAST MEDICAL HISTORY

1. Do you have diabetes? ___yes ___no
2. Do you have/had hypertension? ___yes ___no
3. Do you have heart disease? ___yes ___no
4. Do you have a heart murmur? ___yes ___no
5. Do you have/had kidney disease? ___yes ___no
6. Have you ever been treated for psychiatric problems? ___yes ___no
7. Have you ever had rheumatic fever? ___yes ___no
8. Do you have mitral valve prolapse? ___yes ___no
9. Have you ever had a urinary tract infection? ___yes ___no
10. Have you ever had hepatitis/liver disease? ___yes ___no
11. Have you ever had varicosities/phlebitis? ___yes ___no
12. Do you have any thyroid problems? ___yes ___no
13. Have you had any major accidents? ___yes ___no
14. Have you ever had any blood transfusions? ___yes ___no
15. Do you have asthma/lung disease? ___yes ___no
16. Do you have lupus? ___yes ___no
17. Do you have arthritis? ___yes ___no
18. Do you have any Drug Allergies? ___yes ___no
    If yes, please list:

_____

19. Please list any surgeries (include year):

_____
_____
_____
_____

20. Please list any other hospitalizations (include year & reason):

_____
_____
_____
_____

21. Have you had any anesthesia complications? ___yes ___no
    If yes, please explain:

_____

22. Have you ever been anemic? ___yes ___no
23. Do you have an Internist or Family or GYN doctor? ___yes ___no
    Please list name & phone number:

_____ phone: _____
_____ phone: _____
_____ phone: _____

24. Have you had your cholesterol checked? ___yes ___no
    If yes, date last checked?_____
    Was it normal? ___yes ___no

25. Please list any medications you are currently taking:

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

26. Do you have allergies?
If yes, list

## SOCIAL HABITS

1. Do you smoke? ___yes ___no packs/day ____

2. Do you drink alcohol? ___yes ___no ____daily ____weekly _____ seldom ____ None

3. Do you use recreational drugs, if so which ones?

**Would you like to receive an in office $50 credit?_____**
(When you refer a friend and they receive pellets)