

Symptoms

Please identify your current symptoms and rate severity (mild, moderate, severe) and describe any special circumstances.

Symptoms	Yes	No	Severity (mild, moderate, severe)	Special Circumstances
Insomnia / difficulty sleeping				
Hot flashes				
Night sweats				
Cold intolerance (always cold when others are comfortable)				
Cold extremities				
Headache				
Loss of scalp hair				
Loss of pubic hair				
Dry coarse hair				
Dry skin				
Brittle nails				
Acne				
Poor skin elasticity				
Oily skin				
Wrinkles/lines on face				
Sun spots (face and/or hands)				
Puffiness of face and eyelids				
Blurred vision				
Thinning of skin				
Loss of bladder control				
Urinary Frequency/Urgency				
Constipation				
Frequent yeast infections				

Symptoms	Yes	No	Severity (mild, moderate, severe)	Special Circumstances
Frequent urinary tract infections				
Vaginal Shrinking				
Vaginal Dryness				
Painful intercourse				
Diminished ability to reach orgasm				
Low Libido				
Absent menses not related to menopause or hysterectomy				
Cramps				
Heavy or irregular menses				
Uterine fibroids				
Edema/water retention				
Bloating				
Fibrocystic breasts				
Swollen breasts				
Breast tenderness				
Lactation/milk production when not nursing				
Food cravings				
Fuzzy thinking				
Inability to concentrate				
Short term memory loss				
Depression				
Moodiness				
Irritability				
Emotional swings				
Anxiety				
Shortness of breath				
Heart palpitations				
Fatigue/lack of energy				

Poor appetite				
Weight Gain				
Vocal hoarseness				

Objective Information

Please provide as much information as possible.

Height: _____

Weight: _____

What is your waist circumference at the navel? _____

Are you concerned with your current weight? Y/N

Do you have weight management goals? Y/N

If Yes, explain: _____

Blood Pressure: Last checked: _____ Reading: _____

Pulse: Last checked: _____ Rate: _____

Have you ever had a bone density scan? Y/N

If "Yes", Date: _____ Results: _____

Have you ever had your cholesterol checked? Y/N

If "Yes", Date: _____

Results: Total _____ HDL _____ LDL _____ Triglycerides _____

Have you ever had your thyroid tested? Y/N

If "Yes", Date: _____

Results: TSH _____ Total T4 _____ Free T4 _____ Total T3 _____ Free T3 _____

Do you have regular mammograms? Y/N

If "Yes", Date: _____ Results: _____

Have you ever had an abnormal mammogram? Y/N

Have you ever had a breast biopsy? Y/N

Have you had lab work of hormones? Y/N

If "Yes", was it within the last year? Y/N

Age of first period: _____

Are you still menstruating? Y/N

If "Yes", date of last period? _____

Have you experienced a change in frequency or in intensity of your period? Y/N

How many times have you been pregnant? _____

How many children have you delivered? _____

Your age at your first live birth: _____

Your Current Medical Conditions

Disease state	Yes	No
Heart disease		
High blood pressure		
Stroke		
Varicose veins		
Clotting defects		
Diabetes		
Kidney disease		
Epilepsy		
Fractures		
Arthritis		
Colitis		
Gall bladder disease		
Asthma		
Chronic fatigue syndrome		
Fibromyalgia		
Cancer		
Fibroids		
Endometriosis		
Fibrocystic breast disease		
Abnormal vaginal bleeding		
Abnormal pap		
Hypothyroid		
Hyperthyroid		

Other:		
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Please Specify: _____

Additional Information

Current Medications, Hormone Therapy, Vitamins and/or Supplements: _____

Drug Allergies: _____

Please list any surgeries you have had (hysterectomy, oophrectomy/ovaries removed, tubal ligation, etc):

Is there any history of cancer in your family? (breast, ovarian, or endometrial) Y/N

If "Yes", What relationship and age of occurrence/diagnosis? _____

Is there any history of diabetes (type 2 / non-insulin dependent) in your family? Y/N

If "Yes", What relationship and age of occurrence/diagnosis? _____

Is there any history of heart attacks, coronary artery bypass, or strokes in you parent(s) or sibling(s)? Y/N

If "Yes", What relationship and age of occurrence/diagnosis? _____

Describe what you typically eat for the following:

Breakfast: _____ Lunch: _____

_____ Dinner: _____

Snacks / Dessert: _____

Do you get regular exercise? Y/N

If "Yes", Describe: _____

days/week: _____

Do you use tobacco products? Y/N

If "Yes", How many per day? _____ How long? _____

Do you use alcohol products? Y/N

If "Yes", How many drinks per day? _____ How long? _____

Do you use caffeine products? Y/N

If "Yes", How many drinks per day? _____ How long? _____