Patient Information

Date: _____

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: ____/____/____ Ph#: _____-_____-_____

Preferred Pharmacy (address or phone number)? _____

BHRT CHECKLIST FOR WOMEN

Symptom (please check mark)

	Never	Mild	Moderate	Severe
Depressive mood				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				
Other symptoms that concern you:				

MEDICAL HISTORY INTAKE

Name: _____

Habits: ( ) I smoke cigarettes or cigars_____per day. ( ) I drink alcoholic beverages _____ per week. ( ) I use caffeine_____a day. ( ) I use Controlled Substances _____ a week.

Are you currently taking any medications, pills, or drugs including Nutritional Supplements/Vitamins:

_____

Any drug Allergies ?

_____

Current Birth control method: _____

Current Hormone Replacement Therapy: _____

Past Hormone Replacement Therapy: _____

Last Menstrual Period (estimate year if unknown): _____

Do you suffer from PMS (if yesexplain): _____

Total Number of Pregnancies: _____

Date of Last Pregnancy: _____

Have you had a hysterectomy:_____year_____

Have you had your ovaries removed: _____year_____

Have you had your tubes tied: _____

Any other Surgeries, list all and when:

_____

_____

_____

Do you have a personal or family history of any of the following?

Uterine Cancer: Yes No (relationship) _____

Ovarian Cancer: Yes No (relationship) _____

Breast Cancer: Yes No (relationship) _____

Fibrocystic Breast: Yes No (relationship) _____

Polycystic Ovarian Syndrome Yes No (relationship) _____

Have you had any of the following tests?

Mammogram: Yes (Date) _____ No Abnormal? Yes No

PAP Smear : Yes(Date) _____ No Abnormal? Yes No

Pelvic/Vaginal US: Yes (Date) _____ No

Abnormal? Yes No

Please check if you have any of the following:

Alzheimer's Disease	
Frequent Headaches	
Stroke	
Epilepsy or Seizures	
Glaucoma	
Hay Fever	
Sinus Trouble	
Asthma	
Hypothyroid	
Hyperthyroid	
Parathyroid Disease	
High Blood Pressure	
Low Blood Pressure	
Blood Disease	
Hemophilia	
Bruise Easily	
Sickle Cell Disease	
Anemia	
Excessive Bleeding	
AIDS / HIV Positive	
Hepatitis	
Leukemia	
Heart Disease	
Heart Pace Maker	
Artificial Heart Valve	
Liver Disease	
G.I. Disease	
Kidney Problems	
Diabetes	
Venereal Disease	
Genital Herpes	
Fainting/ Dizzy spells	
Artificial Joint	
Swelling of the Limbs	
Recent Weight Loss	
Cancer	
Radiation Treatment	
Drug Addiction	
Psychiatric Care	

Have you ever had any serious illness not listed above? Yes No If yes, please explain:

_____

Are you under a physician's care now, or have been in the past 2 years? Yes No If yes, please explain:

_____

_____

Physician:_____ Phone Number: _____