



KORU PHARMACY

NUTRITION | WELLNESS



CONFIDENTIAL HORMONE EVALUATION

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____
Street City State Zip

Phone: _____ Email: _____

Height: _____ Weight: _____ Desired Weight: _____

How often and how much?

Do you use tobacco? Yes No _____

Do you use alcohol? Yes No _____

Do you use caffeine? Yes No _____

Do you exercise? Yes No _____

Allergies: Please list any allergies and describe the reaction that occurred

Drugs: _____

Foods: _____

Other: _____

Over-the-Counter Medication History: Please list all non-prescription medications that you are taking. (Include vitamins, herbals, and supplements):

Current Prescription Medications (including hormones):

Medication name | Strength | Date started | How often per day

Menstrual History

Age at first period _____ Date of last menstrual period _____

Length of cycle _____ Time between cycles _____

Menstrual Cramping? Yes No

Menstrual Pain? Yes No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? Yes No

If yes, please describe: _____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? Yes No

If yes, please describe: _____

Use of hormonal birth control: Birth control pills Patch NuvaRing Other _____

Date started: _____

Any problems with hormonal birth control? Yes No

If yes, explain _____

Use of other contraception? Yes No Condoms Diaphragm IUD Partner vasectomy

Obstetric History

Pregnancies _____ Miscarriages _____ Children _____

Hysterectomy _____ Oophorectomy _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? Yes No

If yes, please explain:

Last Pap test: _____ Normal Abnormal

Last mammogram: _____ Normal Abnormal

Last bone density: _____ Results: _____ Normal High Low

Other tests and dates: _____

Other Gynecological Symptoms: (Check if applicable)

Endometriosis Infertility Fibrocystic breasts Vaginal infection Fibroids

Ovarian cysts Pelvic inflammatory disease Reproductive cancer

Menopause History

Are you in menopause? Yes No *If yes, age at last period:* _____

Was it surgical menopause? Yes No *If yes, explain:* _____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

- Hot flashes Mood swings Concentration/memory problems Headaches Joint pain
Vaginal dryness Weight gain Decreased libido Loss of control of urine Palpitations

Are you on hormone replacement therapy? Yes No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? _____

Current Hormone Usage:

Do you take hormones of any kind? Yes No

If so, list (include birth control pills, HRT, or natural hormone (s): Brand

Hormone	Dose	How Often	Date Started

If you are currently taking hormones, **what specific symptoms are improved?** *Please list:*

If you are currently taking hormones, **are you experiencing any unwanted side effects?** *Please list:*

Symptoms Questionnaire

	Absent	Mild	Moderate	Severe
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Incontinence	_____	_____	_____	_____
Bleeding Changes	_____	_____	_____	_____
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain (waist)	_____	_____	_____	_____
Weight gain (hips)	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Dry skin/hair	_____	_____	_____	_____
Thinning skin	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____
Brittle/dry nails	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____
Sleep disturbances	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Foggy Thinking	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Oily skin	_____	_____	_____	_____
Sugar cravings	_____	_____	_____	_____
Bone loss	_____	_____	_____	_____
Decreased muscle mass	_____	_____	_____	_____
Increased facial/body hair	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Low libido	_____	_____	_____	_____
Heart palpitations	_____	_____	_____	_____
Low blood pressure	_____	_____	_____	_____
Slow pulse rate	_____	_____	_____	_____
Swelling/puffy eyes/face	_____	_____	_____	_____
Stress	_____	_____	_____	_____
Candida infection	_____	_____	_____	_____
Cold hands/feet	_____	_____	_____	_____

Other: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Medical History

Please check appropriate box if applicable and provide date of onset

GASTROINTESTINAL

- Irritable Bowel Syndrome _____
 Inflammatory Bowel Disease _____
 Crohn's disease _____
 Ulcerative Colitis _____
 Gastritis or Peptic Ulcer Disease _____
 GERD (reflux) _____
 Celiac Disease _____
 Other _____

Date of onset:

CARDIOVASCULAR

- Heart Attack _____
 Other Heart Disease _____
 Stroke _____
 Elevated Cholesterol _____
 Arrhythmia (irregular heart rate) _____
 Hypertension (high blood pressure) _____
 Rheumatic Fever _____
 Mitral Valve Prolapse _____
 Other: _____

Date of onset:

CANCER

- Lung cancer _____
 Breast cancer _____
 Colon cancer _____
 Ovarian cancer _____
 Prostate cancer _____
 Skin cancer _____

INFLAMMATORY/AUTOIMMUNE

- Chronic Fatigue Syndrome _____
 Rheumatoid Arthritis _____
 SLE _____
 Immune Deficiency Disease _____
 Herpes-Genital _____
 Infectious Disease _____
 Poor immune function _____
 Frequent infections _____
 Other: _____

GENITAL AND URINARY SYSTEMS

- Kidney stones _____
 Gout _____
 Interstitial cystitis _____
 Frequent urinary tract infections _____
 Frequent yeast infections _____
 Erectile/sexual Dysfunction _____
 Other: _____

SKIN CONDITIONS

- Eczema _____
 Psoriasis _____
 Acne _____
 Melanoma _____
 Rosacea _____

MUSCULOSKELETAL/PAIN

- Osteoarthritis _____
 Fibromyalgia _____
 Chronic Pain _____
 Other: _____

MEN'S HISTORY (for men only)

- Prostate Enlargement _____
 Prostate infection _____
 Change in Libido _____
 Impotence _____
 Difficulty obtaining an erection _____
 Difficulty maintaining an erection _____
 Nocturia (urination at night) _____

How many times at night? _____

- Urgency/Change in Urinary Stream _____
 Loss of Control of Urine _____

FAMILY HISTORY (please specify relationship)

- Breast cancer _____
 Ovarian cancer _____
 Uterine cancer _____
 Fibrocystic breast _____
 Heart disease _____
 Osteoporosis _____
 Diabetes _____

Have you had a PSA done? Yes No
PSA Level: 0-2 2-4 4-10 >10