HORMONE REPLACEMENT THERAPY PATIENT ENCOUNTER

PATIENT:_____DATE:_____

AGE:_____SEX:_____HT:_____WT:_____MARITAL STATUS: _____RACE_____

ADDRESS:_____

HOME PHONE:_____CELL PHONE:_____

PRINT EMAIL:_____

(WHAT IS YOUR FIRST CHOICE FOR ME TO COMMUNICATE WITH YOU--HOME PHONE, CELL, EMAIL?)

CIRCLE AND EXPLAIN IF YOUR MEDICAL HISTORY CONTAINS ANY OF THE FOLLOWING:

HEADACHES:_____MIGRANES?_____

CANCER:_____

DIABETES:_____

HEART DISEASE:_____

ARTHRITIS or GENERAL MUSCLE ACHES:_____

LIVER DISEASE (HEPATITIS, CIRRHOSIS):_____

AUTOIMMUNE DISEASE (ex: LUPUS): _____

NEUROLOGIC DISEASE: (STROKE, SEIZURES)_____

MEMORY PROBLEMS (FOGGY THINKING)_____

PSYCOLOGICAL ISSUES (DEPRESSION, ANXIETY, BIPOLAR):_____

LUNG, KIDNEY, STOMACH, INTESTINES:_____

BLADDER (GET UP FREQ. AT NIGHT TO URINATE?)_____

HIV/AIDS_____

SMOKING, AND HOW MANY PACKS A DAY:_____HOW MANY YEARS?_____

ALCOHOL, AND HOW MUCH A DAY:_____

OSTEOPOROSIS (BONE THINNING):_____

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DO YOU HAVE ANY OF THE FOLLOWING?

ENERGY LOSS:_____

SLEEP PROBLEMS:_____

DECREASED LIBIDO:_____

WEIGHT CONTROL—COULD BE GAIN OR LOSS?:_____

SELF IMAGE ISSUES:_____

WOMAN ONLY

DO YOU HAVE YOUR UTERUS?_____IF NO, WHEN WAS YOUR HYSTERECTOMY?_____

IF YES, DO YOU STILL HAVE MENSES?_____REGULAR?_____IRREGULAR_____

DO YOU HAVE YOUR OVARIES?_____IF NO, WHEN WAS YOUR OOPHERECTOMY?_____

PREMENSTRUAL TENSION_____

HOT FLASHES_____

NIGHT SWEATS_____

DRY SKIN_____

DRY HAIR_____

BRITTLE NAILS_____

VAGINAL DRYNESS_____

VAGINAL PAIN ON INTERCOURSE_____

HISTORY OF SEXUALLY TRANSMITTED DISEASE_____IF YES, WHICH_____

PERSONAL OR FAMILY HISTORY OF BREAST, UTERINE, or COLON CANCER (Circle Which)_____

DATE OF LAST PELVIC EXAM AND PAP SMEAR: MONTH_____YEAR_____

DATE OF LAST MAMMOGRAM: MONTH_____YEAR_____

DO YOU USE BIRTH CONTROL, IF SO WHICH_____

MEN

EVER TOLD YOU HAVE AN ENLARGED PROSTATE_____

DIFFICULTY STARTING TO URINATE_____ or CONTROL OF URINATION_____

LOW LIBIDO_____

HIGH LIBIDO_____

DIFFICULTY ATTAINING OR MAINTAINING ERECTION_____

HAVE YOU USED VIAGRA (or OTHER)_____DID IT HELP?_____

PAIN ON EJACULATION_____

HISTORY OF SEXUALLY TRANSMITTED DISEASE_____IF YES, WHICH, WHEN_____

DATE OF LAST PROSTATE EXAM:_____

IF KNOWN, LAST PSA BLOOD LEVEL_____

PSYCHO-PHYSIOLOGIC EVALUATION-Men and Women

Check if any of the following symptoms apply to you.

_____RAPID MOOD SWING

_____IMPATIENT, MOODY, NERVOUS

_____LACK OF MENTAL ALERTNESS, FOGGY THINKING

_____DEPRESSION

_____DIFFICULTY CONCENTRATING

SKIN AND HAIR

_____DRY, BRITTLE, THINNING HAIR

_____HAIR AND NAILS SLOW GROWING

_____DRY, THINNING SKIN

_____ACNE

_____WRINKLING SKIN

METABOLIC

_____SWOLLEN OR BULGING EYES

_____FEEL COLD FREQUENTLY

_____CAN'T GAIN WEIGHT

_____CAN'T LOSE WEIGHT

_____THINNING OR LOSS OF OUTSIDE PART OF EYEBROWS

_____INCREASED THIRST

_____CRAVE SWEETS IF AWAKEN IN THE MIDDLE OF THE NIGHT

_____CRAVE SALTY FOODS

KIDNEY, BOWLS, BLADDER

_____FREQUENT OR BURNING URINATION

_____BLOOD IN URINE OR _____BLOOD IN STOOL

_____LOSS OF BLADDER CONTROL OR _____LOSS OF BOWEL CONTROL

PLEASE DESCRIBE WHAT AREAS HAVE CHANGED, IF ANY, OVER THE LAST 10 YEARS

(I know some of this is repetitive)

BODY FAT:	INCREASE_____DECREASE_____NO CHANGE_____
AEROBIC CAPACITY:	INCREASE_____DECREASE_____NO CHANGE_____
ENERGY LEVEL:	INCREASE_____DECREASE_____NO CHANGE_____
BONE DENSITY:	INCREASE_____DECREASE_____NO CHANGE_____DON'T KNOW_____
SKIN FIRMNESS:	INCREASE_____DECREASE_____NO CHANGE_____
EPISODES OF INFECTIONS:	INCREASE_____DECREASE_____NO CHANGE_____
HAIR LOSS	INCREASE_____DECREASE_____NO CHANGE_____
LIBIDO	INCREASE_____DECREASE_____NO CHANGE_____
FREQUENCY OF SEX	INCREASE_____DECREASE_____NO CHANGE_____
ENDURANCE DURING SEX	INCREASE_____DECREASE_____NO CHANGE_____
MEMORY/COGNITION	INCREASE_____DECREASE_____NO CHANGE_____

DO YOU CURRENTLY TAKE ANY NUTRITONAL SUPPLEMENT? (ex. Vitamins) IF SO, PLEASE LIST:

_____
_____
_____
_____
_____
_____
_____
_____

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DO YOU CURRENTLY TAKE ANY HORMONE REPLACEMENT? IF SO, PLEASE CHECK AND WRITE DOSE:

_____PREMARIN

_____PROVERA

_____FEMRING

_____OTHER ESTROGEN - ESTRADIOL, ESTRIOL, ESTRACE, ESTRONE

_____TAMOXIFEN

_____ARIMIDEX

_____THRYROID - SYNTHROID, LEVOTHYROXIN

_____MELATONIN

_____DHEA

_____PREGNENOLONE

_____TESTOSTERONE

_____PROGESTERONE

_____HUMAN GROWTH HORMONE

OTHERS:

_____

_____

_____