Hormone Evaluation

CLIENT INTAKE FORM

Today's Date:___________________________

Name: ____ Birthdate: ______________________ Age: _____

Alberta Health Care Number: ________________________________ Gender: __________________________

Height: ___________________ Weight: ___________________

Address: ____ City: ______________________ Province: ____

Postal Code: ________________ Phone Number: ______________________ Email: ___________________

Emergency Contact Information: ____

Family Physician Name: _______________________ Family Physician Phone Number: ___________________

Allergies: Please check all that apply.

- ☐ penicillin ☐ sulfonamides ☐ other antibiotics: _________________
- ☐ morphine ☐ codeine ☐ aspirin ☐ other medications: _________________________
- ☐ dye allergies ☐ pet allergies: _________________ ☐ seasonal allergies: _________________
- ☐ food allergies: _________________
- ☐ no known allergies
- ☐ other: _________________________

Please describe the allergic reaction you experienced and when it occurred: ______________________________

Over-the-counter (OTC) medications:

Please check all products that you use occasionally or regularly.

- ☐ Pain Reliever
- ☐ Aspirin
- ☐ Acetaminophen (e.g.Tylenol)
- ☐ Ibuprofen (e.g. Advil, Motrin)
- ☐ Naproxen (e.g. Aleve)
- ☐ Decongestant product
- ☐ Cough suppressant
- ☐ Antihistamine product
- ☐ Combination product (cough+cold reliever)
- ☐ Sleep aids
- ☐ Antidiarrheals (e.g.Imodium, Pepto Bismol)
- ☐ Laxatives/stool softeners
- ☐ Diet aids/weight loss products
- ☐ Antacids
- ☐ Acid blockers
- ☐ Other (please list): ________________________________

Nutritional/Natural Supplements: Please identify and list the products you are using:

- ☐ vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
- ☐ minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- ☐ herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- ☐ enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- ☐ nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)
- ☐ others (glucosamine, etc.): ____

Current Prescription Medications:

Medication Name	Strength	How often per day	Date started
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

Please list any hormones previously taken or currently taking:

Hormone name	Date started	Date stopped	Reason
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___
___	___	___	___

Immunizations and dates:

- ☐ Tetanus ___
- ☐ Hepatitis ___
- ☐ Influenza ___
- ☐ COVID-19; last dose? ___
- ☐ Pneumonia ___
- ☐ Chickenpox ___
- ☐ MMR ___

Medical history/conditions:

- ☐ ___
- ☐ ___
- ☐ ___
- ☐ ___
- ☐ ___
- ☐ ___

Surgeries:

Type	Year	Reason
___	___	___
___	___	___
___	___	___

HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise
- ☐ Sedentary (No exercise)
- ☐ Mild exercise (i.e. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 mins)
- ☐ Regular vigorous exercise (i.e. work or recreation 4x/week for 30 minutes)

Diet
- Are you dieting? ☐ Yes ☐ No
- If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No
- # of meals you eat on an average day? ___

- Rate salt intake ☐ High ☐ Medium ☐ Low
- Rate fat intake ☐ High ☐ Medium ☐ Low

Caffeine ☐ None ☐ Coffee ☐ Tea ☐ Cola
- # cups/cans per day? ______________

Alcohol
- Do you drink alcohol? ☐ Yes ☐ No
- If yes, what kind? __________________________
- How many drinks per week? ___________________________
- Are you concerned about the amount you drink? ☐ Yes ☐ No
- Have you considered stopping? ☐ Yes ☐ No
- Have you ever experienced blackouts? ☐ Yes ☐ No
- Are you prone to "binge" drinking? ☐ Yes ☐ No

Tobacco
- Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes - packs/day _____ ☐ Chew - #/day_____ ☐ Pipe - #/day_____ ☐ Cigars - #/day_____
- # of years _____ - Or year quit: _________

Drugs
- Do you currently use recreational or street drugs? ☐ Yes ☐ No
- Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Sex
- Are you sexually active? ☐ Yes ☐ No
- If yes, are you trying for a pregnancy? ☐ Yes ☐ No
- If not trying for a pregnancy, list contraceptive or barrier method used: ________________________
- Any discomfort with intercourse? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

Relative	Age	Significant Health Problems
__________________________	____________________	____
__________________________	____________________	____
__________________________	____________________	____
__________________________	____________________	____
__________________________	____________________	____

MENTAL HEALTH

Is stress a major problem for you? ☐ Yes ☐ No

Do you feel depressed? ☐ Yes ☐ No

Do you panic when stressed? ☐ Yes ☐ No

Do you have problems with eating or your appetite? ☐ Yes ☐ No

Do you cry frequently? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Have you ever been to a therapist? ☐ Yes ☐ No

WOMEN ONLY

When was your last period? ____

How many days did it last? ____

Do you experience heavy periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No

How many pregnancies have you had? ____________ How many children? ________________

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Have you had a D&C, hysterectomy, or Cesarean? ☐ Yes ☐ No

Ovaries removed? ☐ Yes ☐ No

Have you had a tubal ligation? ☐ Yes ☐ No

Any urinary tract, bladder, or kidney infections within the last year? ☐ Yes ☐ No

Any blood in your urine? ☐ Yes ☐ No

Any problems with control of urination? ☐ Yes ☐ No

Any hot flashes or sweating at night? ☐ Yes ☐ No

Any menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? ☐ Yes ☐ No

Any recent breast tenderness, lumps, or nipple discharge? ☐ Yes ☐ No

Have you ever used oral contraceptives?

☐ Yes: ____ ☐ No

If yes, any issues? Please describe. ____

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

Uterine Cancer _____________ Family member(s) _____________

Ovarian Cancer _____________ Family member(s) _____________

Fibrocystic breast _____________ Family member(s) _____________

Breast cancer _____________ Family member(s) _____________

Heart Disease _____________ Family member(s) _____________

Osteoporosis _____________ Family member(s) _____________

Have you had any of the following tests performed? Check those that apply and note the date of the last test.

Mammography ☐ No ☐ Yes Date: _______________________

PAP Smear ☐ No ☐ Yes Date: _______________________

MEN ONLY

Do you usually get up to urinate during the night? ☐ Yes ☐ No

If yes, # of times ______________

Do you feel pain or burning with urination? ☐ Yes ☐ No

Any blood in your urine? ☐ Yes ☐ No

Do you feel burning discharge from penis? ☐ Yes ☐ No

Has the force of your urination decreased? ☐ Yes ☐ No

Have you had any kidney, bladder, or prostate infections within the last 12 months? ☐ Yes ☐ No

Do you have any problems emptying your bladder completely? ☐ Yes ☐ No

Any difficulty with erection or ejaculation? ☐ Yes ☐ No

Any testicle pain or swelling? ☐ Yes ☐ No

Date of last prostate and rectal exam? __________________________

How did you arrive at the decision to consider Bioidentical Hormone Replacement Therapy?

◻ Physician ◻ Self ◻ Friend/Family Member ◻ Other: ______________________

What are your goals with taking BHRT?

Please write down any questions you have about Bioidentical Hormone Replacement Therapy.

Please indicate the degree to which you experience the following:

SYMPTOM	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast				
Weight Gain				
Heavy/Irregular Menses				
Hot Flashes				
Dry Skin/Hair				
Anxiety				
Depression				
Night Sweats				
Vaginal Dryness				
Headaches				
Irritability				
Mood Swings				
Breast Tenderness				
Sleep Disturbances/Insomnia				
Genital Dryness, burning and irritation				
Fluid Retention				
Breakthrough Bleeding				
Fatigue				
Loss of Memory, Trouble Concentrating				
Bladder Symptoms (urgency, UTI's)				
Arthritis				
Difficulty/Increased Time to Reach Climax				
Decreased Sex Drive				
Pain During Sexual Activity				
Hair Loss				