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**Hormone Assessment Patient Information Sheet**

Date \_\_\_\_\_ Patient's Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ zip \_\_\_\_\_

**Please answer all the questions below**

Have you had a hysterectomy? Yes \_\_\_ No \_\_\_ Date \_\_\_\_\_  
 Have you been on hormone replacement since your hysterectomy? Yes \_\_\_ No \_\_\_  
 What did you take? \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_  
 How much coffee \_\_\_ tea \_\_\_ coke \_\_\_ a day? Are you a smoker? Yes \_\_\_ No \_\_\_  
 Have you had children? Yes \_\_\_ No \_\_\_ Any complications during or after birth?

What medications are you taking now? \_\_\_\_\_

What vitamin supplements are you taking? \_\_\_\_\_

How many days do you exercise a week? 1\_2\_3\_4\_5\_6\_7\_ What do you do? \_\_\_\_\_

Is there a family history of any cancer and who? \_\_\_\_\_

Uterine Cancer \_\_\_ Who \_\_\_\_\_

Ovarian Cancer \_\_\_ Who \_\_\_\_\_

Breast Cancer \_\_\_ Who \_\_\_\_\_

Osteoporosis \_\_\_ Who \_\_\_\_\_

Heart Disease \_\_\_ Who \_\_\_\_\_

**Have you experienced any of the following symptoms recently?**

Symptoms	Yes	No	Symptoms	Yes	No
Sleep disruption			Fatigue		
Short term memory loss			Weight gain		
Depression			Decreased sex drive		
Irritability			Harder to reach climax		
Nervousness			Vaginal dryness		
Headaches			Fluid retention		
Hot flashes			Breast tenderness		
Night sweats			Bladder symptoms		
Dry skin			Hair loss		
Arthritis			Easily angered		

Do you have any questions for me, or comments you would like to share?