Lynch Primary Care

Phone 410.638.5339 • Fax 410.638.8877

Confidential Female Hormone Replacement Evaluation

Date: Phone: Email:

Name: Birth date: Age:

Address:
Street/ P.O. Box City State Zip

Occupation:

How many pregnancies have you had? How many children? How many living?

Any interrupted pregnancies? [ ] No [ ] Yes
Have you had a hysterectomy? [ ] No [ ] Yes If yes, date of surgery:
Ovaries removed? [ ] No [ ] Yes One: Both:
Have you had a tubal ligation? [ ] No [ ] Yes If yes, date:
Have you had a mammogram? [ ] No [ ] Yes If yes, date of most recent one:
Have you had a PAP smear? [ ] No [ ] Yes If yes, date of most recent one:
Have you had a Dexascan®? [ ] No [ ] Yes If yes, date of most recent one:
Have you ever had what YOU would consider to be abnormal periods? [ ] No [ ] Yes
If yes, explain symptoms, frequency, etc.....

When was your last period? How long did it last?
Did you have, or do you ever have Premenstrual Syndrome (PMS)? [ ] No [ ] Yes
If yes, describe symptoms:

List hormones previousley taken:

Hormone:	Date started	Date stopped	Reason stopped
Hormone:	Date started	Date stopped	Reason stopped
Hormone:	Date started	Date stopped	Reason stopped

Have you ever used oral contraceptives? [ ] No [ ] Yes If yes, any problems? [ ] No [ ] Yes
If yes, explain:

Are you currently using oral contraceptives to prevent pregnancy? [ ] No [ ] Yes
If you are currently using birth control is pregnancy a concern? [ ] No [ ] Yes
Are you currently using any other methods of birth control? [ ] No [ ] Yes (Please List)

Medical Conditions/Diseases: (Check all that apply to you.)

[ ] Heart Disease	[ ] High cholesterol or lipids	[ ] High blood pressure	[ ] Cancer
[ ] Ulcers	[ ] Thyroid Disease	[ ] Hormonal related issues	[ ] Lung Condition
[ ] Diabetes	[ ] Arthritis or joint problems	[ ] Blood clotting problems	[ ] Depression
[ ] Epilepsy	[ ] Headaches/Migraines	[ ] Eye Disease (glaucoma, etc.)	[ ]Fibromyalagia

Other, list:

Patient Name:

Do you have family history of any of the following? (check all that apply to you)

[ ] Ovarian Cancer [ ] Uterine Cancer [ ] Fibrocystic Breast [ ] Heart Disease [ ]Osteoporosis
[ ] Breast cancer If checked, Relationship? _____; At what age?_____
Estrogen positive or producing?

Please list your surgery history:

Date: What: Where:

Date: What: Where:

Date: What: Where:

Hormone Replacement Therapy Patient Information Sheet
(Please place "x" on line(s) that apply)

	Yes	No	Light	Moderate	Severe
Weight Gain					
Heavy/Irregular Menses					
Hot Flashes					
Dry Skin/ Hair					
Anxiety					
Depression					
Night Sweats					
Vaginal Dryness					
Headaches					
Irritability					
Mood Swings					
Breast Tenderness					
Sleep Disturbance/ Insomnia					
Cramps					
Fluid retention					
Breakthrough Bleeding					
Fatigue					
Loss of memory					
Bladder Symptoms					
Arthritis					
Harder to reach climax					
Decreased sex drive					
Hair loss					

Patient Name: _____

List current prescriptions /medications being taken:

Medication name:	Strength	Frequency	Date Started
Medication name:	Strength	Frequency	Date Started
Medication name:	Strength	Frequency	Date Started
Medication name:	Strength	Frequency	Date Started

List current nutritional supplements being taken and identify each product:

Vitamins:

Minerals:

Herbs:

Enzymes:

Nutrition/Protein supplements:

Others:

How did you arrive at the decision to consider Hormone Replacement Therapy/Bio-Identical HRT?
Doctor Self Friend/Family Member Other

What are your goals with taking HRT/BHRT?

Comments:

Provider Signature
Kendal E. O'Hare, MD, FAAFP

Patient Name: _____