



DR. DANA Q. PLETCHER

DR. JEFF J. WATKIN

Hormone Evaluation Consultation

Patient Name _____

Appointment Time _____

Complete this form by printing legibly in ink. This form must be completed in its entirety in order for your evaluation to take place. If categories are not applicable to you in "N/A" or "None."

Consulting Doctor's Name _____

Patient _____

Address/City/State/Zip _____

Phone _____

Sex: M F Age: _____ DOB: _____ Weight: _____ Height: _____

If you are a woman of child bearing age are you pregnant? Yes No

If not, do you intend to become pregnant in coming 2 years? Yes No

Patient

Please list the main hormonal health problems, symptoms and complaints that this consultation will address (in narrative form). _____

Consulting Doctor

Please list the clinical findings/symptoms of the patient. _____

Signature of Consulting Doctor _____ Date: _____

700 Florsheim Drive
Suite 12
Libertyville, Illinois 60048
USA



PATIENT NAME: _____

General Health History

Please mark (X) if you have a personal or family history. Specify the nature and duration of the problem when personal history applies.

Family	Personal	Health Problem	Duration (Personal)
		Blood Pressure	
		Heart Disease	
		Diabetes	
		Stroke	
		Neurological Disorder	
		Cancer	
		Skin Problems	
		Gastrointestinal Problems	
		Liver	
		Asthma	
		Arthritis	
		Osteoporosis	
		Mental Disorder	

Health Data

Please list **most recent result/date/place** of the following tests.

1. Last physical exam _____
2. Bone density test (DEXA) _____
3. NTX or DPD (osteoporosis urine test) _____
4. Colonoscopy/Sigmoidoscopy _____
5. Traveling in a third-world country (date & place) _____
6. HIV Status _____
7. Chest X-Ray _____
8. Serum Cholesterol Count _____
9. EKG (heart exam) _____
10. Tuberculosis (TB) skin test _____
11. Prostate or testicular exam _____
12. Mammogram _____
13. Breast exam _____
14. Hepatitis screen _____

PATIENT NAME: _____

Mark (X) by all applicable statements. I have had, or currently have:

- | | |
|--|---|
| <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Prostate Enlargement |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Premenstrual Syndrome (water
Retention, breast tenderness) | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Endometriosis | |

List other hormonal problems: _____

PATIENT NAME: _____

Menstrual & Reproductive History

Menses

1. Age at which your period began: _____
 - a. Dates your last six periods began: _____, _____, _____, _____, _____, _____
 - b. If menopausal, month and year of last menses _____
2. Regular Periods? () No () Sometimes () Yes
 - a. Periods every ___ days (length of entire cycle)
3. Flow: () Heavy () Medium () Light
 - a. Duration: ___ days (length of flow days)
4. Spotting? () No () Yes Instead of period? () No () Yes
5. Bloating? () No () Yes Weight Gain? () No () Yes
How Much? ___ lbs.
6. Cramps? () No () Yes Duration: ___ days
Intensity: () Mild () Moderate () Severe
7. PMS? () No () Yes Describe: _____
8. Number of days you experience PMS: _____

Pelvic Exam

9. Date of last pelvic exam: _____ Performed By: _____ Reason: _____
10. Date of last PAP smear: _____ Results: _____
11. Previous Abnormal PAP? () No () Yes Date: _____ Results: _____
Therapy: _____
12. Recurring vaginal yeast infections? () No () Yes Onset: _____
Frequency: _____
13. Did you mother take the drug DES during her pregnancy? () No () Yes

Breast Exam

14. Breast Pain or Lumps? () No () Yes Breast Discharge? () No () Yes
15. Date of last mammogram: _____ Results: _____
16. Do you examine your own breasts each month? () No () Yes
If not monthly, how often? _____

Hormones

17. Menopausal? () No () Yes Perimenopausal (beginning symptoms)? () No () Yes
18. Hot Flashes: () No () Yes Onset: _____ Rx: _____
Frequency: _____ times per day/week for _____ minutes.
Intensity: () Mild () Moderate () Severe
19. Painful intercourse? () No () Yes Vaginal dryness? () No () Yes

Pregnancy

20. Currently pregnant? () No () Yes Planning? () No () Yes When? _____
21. Prior pregnancies: # _____ Births: # _____ C-Sections: # _____
Miscarriages: # _____ Abortions: # _____
22. Complications: () No () Yes Describe: _____
23. Sexually active? () No () Yes Type of birth control you use now: _____

PATIENT NAME: _____

Please print name and give dose of all current prescription and hormone medications you are using. Do not list vitamins or minerals.

<u>Medication/Treatment</u>	<u>Dose/Frequency</u>
_____	_____
_____	_____
_____	_____
_____	_____

Please list any known allergies to medications: _____

Please list any surgical procedures and dates (exclude dental): _____

Do you currently have: () Uterus
() No Uterus Date Removed: _____ Reason: _____
() Two Ovaries
() One Ovary Date Removed: _____ Reason: _____
() No Ovaries Date Removed: _____ Reason: _____

Endocrinology History

<u>Duration</u>	<u>Diagnosis</u>	<u>Current Medication & Dose</u>
_____	Pituitary: _____	_____
_____	Thyroid: _____	_____
_____	Parathyroid: _____	_____
_____	Adrenal: _____	_____
_____	Testicles: _____	_____
_____	Ovary: _____	_____

PATIENT NAME: _____

Any other major medical illnesses, please list and describe.

General Endocrine Symptoms Checklist

Please rate the severity of the symptom(s) or condition when it is present by using the Wellness Gauge Scale (1 to 10): **1= symptom is severe** **10=symptom is not severe**

	Fatigue (excessive)		Joint inflammations (Arthritis)
	Nervousness/Anxiety		Low blood pressure
	Depression		Low body temperature
	Irritability (inappropriate anger)		Feel chilled easily
	Apprehensiveness		Cold hands or feet
	Weakness		Loss of appetite
	Lightheadedness/faintness		Indigestion
	Hypoglycemia		Gas, bloating
	Insomnia		Diarrhea or constipation
	Headaches		Food allergies
	Palpitation/rapid heart beat		Airborne allergies
	Difficulty thinking/concentrating		Inactive lifestyle (little exercise)
	Muscle aches/pains (fibromyalgia)		Very active (high exercise level)

PATIENT NAME: _____

Female Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition when it is present by using the Wellness Gauge Scale (1 to 10): **1= symptom is severe** **10=symptom is not severe**

Abdominal pain	Irritable or anxious
Allergies	Meat-eater (rate frequency)
Anger easily	Menstrual cramps
Back pain	Menstrual migraines
Bloating	Mood swings
Chronic stress	Night sweats
Depression	Ovarian cyst(s)
Disinterest in sex/low sex drive	Pain with intercourse
Endometriosis	PMS
Fatigue	Rheumatoid arthritis
Fibrocystic breast disease	Skin problems
Fibroids	Spotting between menses
Fluid retention	Subfertility
Food cravings/binge eating	Tender breasts
Heavy menstrual bleeding	Vaginal dryness
Hot flashes	Yeast problems
Insomnia	
Irregular menstrual cycle	TOTAL SCORE

Past or Present Condition: (1=yes 10=no)

Birth control pills	Loss of height/Bone loss
Cancer: (list type) _____	Miscarriage
DES daughter	Ovarian cancer
Family history of osteoporosis	Premature menopause (<45 yrs old)
Hysterectomy	
Infertility (never able to conceive)	TOTAL SCORE

GRAND TOTAL: _____

