SUGARLAND MEDICAL & AESTHETICS

PCCA CONFIDENTIAL HORMONE EVALUATION MEDICAL HISTORY

Date:

Name: | DOB: | Age:

Address:

City: | State: | Zip:

Phone: | Cell: | Email:

Gender: ☐ Male / ☐ Female | Height: | Weight:

(PLEASE CHECK) *How often & how much?*

Do you use tobacco?	☐ YES	☐ NO	
Do you use alcohol?	☐ YES	☐ NO	
Do you use caffeine?	☐ YES	☐ NO	

Doctor's Name: | Address: | Phone:

Allergies: *Please check all that apply*

☐ Penicillin	☐ Morphine	☐ Dye Allergies	☐ Pet Allergies
☐ Codeine	☐ Aspirin	☐ Nitrate Allergy	☐ Pollen
☐ Sulfa Drug	☐ Food Allergies	☐ No Known Allergies	

Other:

Please describe the allergic reaction you experience when it occurred:

Over the counter (OTC) issues:
Please check all products that you use occasionally or regularly. Check all that apply.

☐ Pain Reliever	☐ Combination products *(cough/cold reliever)*	☐ Aspirin	☐ Ibuprofen
☐ Sleep Aids *(Excedrin PC, Unisom, Sominex)*	☐ Antidiarrheals *(Imodium, Pepto-Bismol)*		☐ Keloprofen
☐ Laxatives/Stool Softener *(Doxiden)*	☐ Cough Suppressant *(Robitussin)*		☐ Antacids *(Maalox/Mylanta)*
☐ Acid Blocker	☐ Diet Aids/Weight Loss Products *(Dexatrim)*		☐ Antihistamine Product *(Chlor-Trimenton)*
☐ Naproxen *(Aleve)*	☐ Decongestant Product *(Sudafred)*		☐ Other *(please list)*

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

(PLEASE CHECK)

Any interrupted pregnancies? ☐ YES ☐ NO | Ovaries removed? ☐ YES ☐ NO

Have you had a hysterectomy? ☐ YES ☐ NO | Have you had tubal ligation? ☐ YES ☐ NO

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

☐ Uterine Cancer ☐ *Family Member(s)* | ☐ Heart Disease ☐ *Family Member(s)*

☐ Ovarian Cancer ☐ *Family Member(s)* | ☐ Osteoporosis ☐ *Family Member(s)*

☐ Fibercystic Breast ☐ *Family Member(s)*

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

Mammogram ☐ YES ☐ NO _____ *DATE* | PAP Smear ☐ YES ☐ NO _____ *DATE*

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles: *(Please Check)* ☐ YES ☐ NO _____ *DATE*

If yes, please explain *(such age when this occurred, symptoms…)*

When was your last menstrual cycle? | How many days did it last?

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ☐ YES ☐ NO

If yes, please explain

Nutritional Supplements:
Please identify & list the products you are using. Check all that apply.

☐ Vitamins | ☐ Minerals | ☐ Herbs | ☐ Enzymes

☐ Nutrition / Protein Supplements | Other:

Medical Conditions / Diseases:
Please check all that apply.

☐ Heart Disease | ☐ Blood clotting problem | ☐ High Cholesterol | ☐ Diabetes

☐ High Blood Pressure | ☐ Arthritis | ☐ Cancer | ☐ Depression

☐ Ulcers | ☐ Epilepsy | ☐ Thyroid Disease | ☐ Headaches / Migraines

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☐ Hormonal Related Issues ☐ Eye Disease ☐ Lung Condition

Other: *Please list*

Current Prescription Medications:

Medication Name	*Strength*	*Date Started*	*How Often Per Day*

List Hormones Previously Taken:

Date Started	*Date Stopped*	*Reason*

Bone Size: ☐ *Small* ☐ *Medium* ☐ *Large**Body Type:** ☐ *Androgenic* ☐ *Estrogenic*

Have you ever used oral contraceptives? ☐ YES ☐ NO **Any problems?** ☐ YES ☐ NO

If YES, describe any problem(s):

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy? *(PLEASE CHECK)*

☐ Doctor ☐ Self ☐ Family/Friend **Other:**

What are your goals with taking BHRT?

Please write any questions you have about Bio-Identical Hormone Replacement Therapy.