



TOTAL WOMAN REJUVENATION HORMONE EVALUATION FORM

Date _____

Doctor you are here to see _____

Social Security No. _____ - _____ - _____ Drivers License No. _____ State _____

Patient Name _____ Age _____ D.O.B. _____

Address _____ City _____ State _____ Zip _____

Email Address _____

Phone (home) _____ (work) _____ (mobile) _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse (name) _____ Occupation _____

Employer _____ Phone _____

INSURANCE _____

Member / I.D. No. _____ Group No. _____

REFERRING PHYSICIAN _____ Phone _____

Is he/she your primary care physician? YES / NO

If not referred by a physician, how did you hear about us? Mailing Website Magazine / Newspaper Television

Referred by Friend _____ Other _____

Who should be notified in case of an emergency? Name _____ Relationship _____

Address _____ Phone _____

PERSONAL HISTORY

ARE YOU: SINGLE MARRIED DIVORCED SEPARATED Other _____

Are you still menstruating? _____ First day of last menstrual cycle? _____ Do you have bleeding between periods? _____

Are your cycles regular? _____ Flow (circle one) LIGHT NORMAL HEAVY

Are you pregnant? _____ Have you ever been pregnant? _____ How many pregnancies? _____

Number of: full term live births _____ miscarriages _____ terminations _____

Have you had a hysterectomy? _____ Tubal Ligation? _____ Do you still have your ovaries? _____

Do you have uterine fibroids? _____ Endometriosis? _____

Date of last PAP smear _____ Result _____ Clinic / Doctor Name _____

Date of last Mammogram (if applicable) _____ Result _____ Place performed _____

Date of last Bone Density Scan (if applicable) _____ Result _____ Place performed _____

Have you ever been tested for HIV? _____ If yes, when _____ Result _____

HAVE YOU EVER HAD ...

YES NO

EXPLAIN (Please include dates)

		Colitis
		Diabetes
		Elevated Cholesterol
		Elevated Triglycerides
		Heart Disease
		Hypertension
		Hepatitis
		Thyroid problems
		Blood clotting problems
		Gallbladder / Liver / Kidney problems
		Irritable Bowel
		Stroke
		Depression
		Mitral Valve Prolapse
		Seizures
		Ulcers
		Asthma
		Headaches
		Major or minor surgical procedure
		Other medical illness

ARE YOU AWARE OF ANY BLOOD RELATIVE WHO HAS OR HAD ...

YES NO

EXPLAIN (If deceased please give ages & dates)

		Colon Cancer
		Breast Cancer
		Ovarian Cancer
		Heart Disease / Heart Attack
		Hypertension
		Diabetes
		Other

DO YOU CURRENTLY ...

YES NO

EXPLAIN

		Smoke	How many packs per day?
		Drink alcohol regularly	How many drinks per day?
		Exercise	What kind? Duration? Days per week?
		ALLERGIES:	
		CURRENT MEDICATIONS:	NAME OF MEDICATION & DOSE
		CURRENT SUPPLEMENTS:	NAME OF SUPPLEMENT & DOSE

Symptom Flow Sheet

Have you experienced any of the following recently?

Please circle the number that best describes your experiences with 1 being extremely mild and 5 being extremely severe.

Sleep disturbance	1	2	3	4	5
Fatigue	1	2	3	4	5
Weight Gain	1	2	3	4	5
Breast Tenderness	1	2	3	4	5
Decreased libido	1	2	3	4	5
Fluid retention	1	2	3	4	5
Sugar cravings	1	2	3	4	5
Hot flashes	1	2	3	4	5
Night Sweats	1	2	3	4	5
Irritability	1	2	3	4	5
Memory loss	1	2	3	4	5
No energy	1	2	3	4	5
Vaginal dryness	1	2	3	4	5
Dry skin	1	2	3	4	5
Depression	1	2	3	4	5
Other (explain)	1	2	3	4	5

Nutritional Assessment

Diet: Describe your daily food intake:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

1. How many servings of vegetables do you eat each day? _____
(one serving = 1/2 cup cooked or raw vegetables or 1 cup salad greens)

2. How many servings of fruit do you eat each day? _____
(one serving = 1 medium piece fruit, 1/2 banana, 1/4 c. dried fruit, 10-12 grapes)

3a. How many servings of grains do you eat each day? _____
(one serving = 1 slice bread, 3/4 c. cereal, 1/2 c. pasta or rice, 1 tortilla, 5 crackers, 1/2 bagel)

3b. How many servings of whole grains do you eat each day? _____
(brown rice, whole wheat, oats, corn, quinoa, barley)

4. How many servings of dairy do you eat each day? _____
(1 cup milk or yogurt, 1.5 oz. cheese)

5a. How many servings of beef do you eat each week? _____
(1 serving = 3 oz.)

5b. Do you eat grass fed beef or commercially raised beef? _____

6a. How many servings of chicken do you eat each week? _____
(1 serving = 3 oz.)

6b. Do you eat free-range organic chicken or commercially raised chicken? _____

7. Do you eat refined sugar every day? _____
(examples: "fruit" yogurts, desserts, granola, most breakfast cereal, soda, "power" bars, chocolate, frozen coffee drinks)

8. Do you eat fish twice per week or take some sort of omega-3 supplement? _____
(such as flaxseed, fish oil, cod liver oil)

9. How many servings of processed meat do you eat each week? _____
(bacon, lunch meat, hot dogs, sausages)

10a. Are you currently taking a Vitamin D supplement? _____

10b. What is the dosage? _____