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FOLLOW UP FEMALE EVALUATION FOR CONSULTATION

From a clinical management point of view it is very useful to gain a detailed history of possible hormone deficiencies. The answers provided in the questions below will allow us to maintain your medical history and will help in advising about current medical therapies. All information will be kept confidential.

PATIENT INSURANCE

Date ___/___/___

Name _____Date of Birth:_____Age_____
Address if new_____City/State/Zip_____
Home Ph _____ Cell Ph _____ Work Ph_____
Email _____(only used by SRCP and not sold to other entities)

Your primary care MD is _____ Your Ob/Gyn is _____
Address _____ Address _____
Tel # _____ Tel # _____

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IS THERE A CHANGE IN YOUR INSURANCE?

Insurance Company _____ ID# _____
Policy Holder _____ Group # _____

Do you have Prescription Insurance – example – Express Scripts, Caremark, Medco …
We will need to obtain a copy of your insurance card.

At this point in the program, my primary goals and/or chief concerns are:

1.

2.

3.

(Check the answer that best describes you)
I complied with the protocol/plan designed for me at the last visit and take my supplements and prescriptions as scheduled:

▫ Everyday ▫ 75% of the time ▫ 50% of the time ▫ 25% of the time
▫ Rarely

What challenges or obstacles keep you from following your plan and taking your supplements and prescriptions as scheduled?

I feel that the protocol/plan I've been following has helped me improve:

▫ by 100% ▫ by 75% ▫ by 50% ▫ 25% or less
▫ no improvement

NEW SYMPTOMS:
1.
2.
3.
4.

HABITS
My appetite is: *circle the most appropriate answer* poor fair good very good out of control
My daily diet usually includes:

breakfast	
snack	
lunch	
snack	
dinner	
snack	

Dietary Restrictions _____
Do you need help with your diet? No Yes
Do you get routine physical exercise? No Yes Type/Frequency/Duration
_____

Do you get at least 20 minutes of relaxation each day? No Yes
Do you get a restful night sleep? Yes No
Do you use tobacco products? Yes No How much _____ Previously _____ How long ____
Do you use alcohol products? Yes No How much _____ Previously _____ How long ____
Do you use caffeine products? Yes No How much _____
How much water do you drink daily? _____
What stressors in your life contribute to your current state of health?

CURRENT MEDICAL STATUS
Describe your current health: ___ Excellent ___ Good ___ Fair ___ Poor

Height _____ Current Weight _____ Ideal Weight _____ Last Period_____

Current Medications: _____ _____
_____ _____
_____ _____

Current Vitamins/Herbs/OTC: _____ _____
_____ _____
_____ _____

Recent Mammogram? _____Date_____ Results _____
Recent Cholesterol screen? ____ Date _____ Results _____
Recent Bone Density scan? ____ Date _____ Results _____
Recent Colonoscopy? _____ Date _____ Results _____
Recent Blood Pressure? _____Date_____ Results_____

SYMPTOMS I – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	ABSENT	MILD	MODERATE	SEVERE
Headaches				
Frequently ill				
Anxiety				
Mood swings				
Fuzzy thinking				
Depression				
Irritability				
Bloating				
Cramping				
Food cravings				
Emotional swings				
Painful/Swollen Breasts				
Difficulty Losing Weight				
Difficulty Falling Asleep				
Difficulty Staying Asleep				

SYMPTOMS II – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	ABSENT	MILD	MODERATE	SEVERE
Hot Flashes				
Shortness of Breath				
Night Sweats				
Inability to Concentrate				
Vaginal Dryness				
Dry Hair/Skin				
Hair Loss				
Anxiety				
Nervousness				
Feel Overwhelmed				
Heart Palpitations				
Fuzzy Thinking				
Short Term Memory Loss				
Frequent UTI's				
Frequent Yeast Infections				
Vaginal Shrinking				
Loss of Pubic Hair				
Painful Intercourse				
Inability to Reach Orgasm				

SYMPTOMS III – Rate each symptom by checking the appropriate modifier. This section is repeated upon subsequent visits to monitor progress.

	ABSENT	MILD	MODERATE	SEVERE
Energy crashes mid-afternoon				
Fatigue, lack of energy				
Craving salty food				
Exhausted easily				
Sensitive to changes in weather				
Loss of Sex Drive				
Dark circles under eyes				
Wounds heal slowly				
Body tender/sensitive to touch				
Feel puffy/swollen all over				
Mind Racing at Bedtime				

SYMPTOMS IV – Check the box if the statement applies to you.

- □ Have unusual fatigue unrelated to exertions?
- □ Feel chillier than others, often needing to wear socks to bed?
- □ Dress in layers because of needing to adjust to various temperatures?
- □ Have feelings of anxiety that sometimes lead to panic?
- □ Have trouble with weight, often eating lightly, still not losing a pound?
- □ Experience aches/pains in muscles/joints unrelated to trauma or exercise?
- □ Have increased problems with digestion or allergies?
- □ Feel mentally sluggish, unfocused, or unusually forgetful?
- □ Know of anyone in your family who has ever had a thyroid problem?
- □ Suffer from dry skin, or are prone to adult acne or eczema?
- □ Go through periods of depression, and/or lowered sex drive?
- □ Family history of diabetes, anemia, rheumatoid arthritis, or early graying hair?
- □ Experience your hair as feeling like straw, dry and easily falling out?
- □ Have significant menopausal symptoms or migraine despite estrogen?
- □ Have history of whiplash or other neck injuries?
- □ Have a history of significant exposure to chlorine, bromine, or fluoride?
- □ Feel utterly exhausted by evening, yet have trouble sleeping?
- □ Do you wake up tired?
- □ First morning temperature (before your feet hit the floor)?_____

If you would like us to share this information with your physician, please initial _____
Please list the physician name and phone # _____

Date _____ Signature _____

Your signature acknowledges your understanding of SRCP's Notice of Privacy Practices according to HIPAA regulations. It does not acknowledge your agreement or any restrictions you may have requested regarding your Protected Health Information.