HARMONY MEDICA, PLLC.

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Today's Date: _____

Name: _____ Birth Date: _____ Age: ____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Email: _____ SS#: _____

Height: _____ Weight: _____ Desired Weight : _____

How Often and how much?

Do you use tobacco? ____ yes ____ no _____
Do you use alcohol? ____ yes ____ no _____
Do you use caffeine? ____ yes ____ no _____

Allergies: Please list all that apply.
Drugs: _____
Foods: _____
Other: _____
Please describe the allergic reaction and when it occurred: _____
_____
_____

Please Check Appropriate:

___African American ___Hispanic ___Mediterranean ___Asian
___Native American ___Caucasian ___Northern European ___Other

Please list current problems in order of priority.

Problem	Mild, Moderate or Severe	Treatment Approach	Success
Example: Postnasal Drip	Moderate	Elimination Diet	Moderate

Patient Name: _____

Past Medical Surgical History

Illness	Self	Family	Illness	Self	Family
Alcoholism / Drug Addiction High			Blood Fats (cholesterol)		
Anemia			High blood pressure (hypertension)		
Asthma			Kidney stones		
Breast disease			Liver disease		
Cancer			Osteoporosis		
Diabetes			Stomach / intestinal issues		
Eating disorder			Thrombophlebitis		
Embolism			Thyroid problems		
Gall bladder disease			Urinary tract infections		
Heart Attack/Angina			Other (describe)		

Surgeries & Hospitalizations

Where	When	Reason

How many pregnancies have you had? ____ How many children? ____ Ages: _____
Have you had a hysterectomy? ____ When? _____
What was the cause of the hysterectomy? _____
Were your ovaries removed? ____ Have you had a tubal ligation? ____ When? _____

Do you have a family history of the following?

Uterine Cancer ____ Family members? _____
Ovarian Cancer ____ Family members? _____
Fibrocystic Breast ____ Family members? _____
Breast Cancer ____ Family members? _____
Heart Disease ____ Family members? _____

Have you had any of the following tests performed?

Mammography ____ Date: _____ Outcome: _____
PAP Smear ____ Date: _____ Outcome: _____
Bone Density ____ Date: _____ Outcome: _____

Patient Name: _____

At what age did your periods begin? _____
Since then have you ever had what YOU would consider to be abnormal cycles? ____
Please explain: _____
_____
_____

When was your last period? _____ How many days did it last? _____
Do you have Premenstrual Syndrome (PMS)? _____ If yes, please explain symptoms:
_____
_____

Nutritional/Natural Supplements: Please identify and list the products you are using:

Vitamins (multiple or single such as B complex, E, C, etc) :_____
_____

Minerals (calcium, magnesium, chromium, etc.) : _____
_____

Herbs (ginseng, ginkgo, biloba, etc) : _____
_____

Enzymes (digestive formulas, papaya, bromelain, CoEnzyme Q10, etc) : _____
_____

Nutrition/protein supplements (shark cartilage, protean powders, amino acids, fish oil, etc._____
_____

Other: _____
_____

Current Hormone Therapies:

Name	Strength	Date Started	How often per day

Patient Name: _____

List hormones previously taken:

Name	Date Started	Date Stopped	Reason

Current Prescription Medications:

Name	Strength	Date Started	How often per day

Have you ever used contraceptives? _____ Any problems? ____ If yes, please describe:

_____
_____
_____
_____

Bone Size: ____ Small ____ Medium ____ Large

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

Doctor _____ Self _____ Friend/Family _____ Other: _____

What are your goals with BHRT or natural hormone replacement therapy use?

_____
_____
_____
_____

Patient Name: _____

Please write down any questions you have about BHRT.

Patient Name: _____

Please rate how severe the following symptoms are for you:

0 = None/Never 1 = Mild or Rare 2 = Moderate 3 = Sever
* (asterisk) if the symptom is intermittent or comes and goes.

___ Hot flashes	___ Evening fatigue	___ Rapid heart beat
___ Night sweats	___ Difficulty sleeping	___ Heart palpitations (irregular)
___ Vaginal dryness	___ Decreased stamina	___ Slow pulse rate
___ Incontinence	___ Headaches/Migraines	___ Cold body temperature (hands/feet)
___ Depression	___ Anxiety	___ Infertility
___ Forgetfulness	___ Irritability	___ Goiter (thyroid enlargement)
___ Foggy thinking	___ Nervousness	___ Decreased sweating
___ Tearfulness	___ Sugar cravings	___ Decreased libido (sex drive)
___ Mood swings	___ Dizziness	___ Allergies
___ Breast tenderness	___ Weight gain – hips	___ Sensitivity to chemicals
___ Fibrocystic Breast	___ Weight gain – waist	___ Decreased muscle size
___ Bleeding changes	___ High cholesterol	___ Thinning skin
___ Uterine fibroids	___ Elevated triglycerides	___ Hearing loss
___ Water retention	___ Dry or brittle hair	___ Rapid aging
___ Acne	___ Brittle or breaking nails	___ Aches & pains
___ Increase facial/ body hair	___ Constipation	___ Fibromyalgia
___ Scalp hair loss	___ Facial swelling/ puffy eyes	___ Bone loss
___ Stress	___ Hoarseness	___ Chocolate cravings
___ Morning fatigue	___ Other _____	

_____

How old are you? _____ How old do you feel? _____