

## MEDICAL HISTORY FORM

Name \_\_\_\_\_ Today's Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
last middle first

Address \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
street

\_\_\_\_\_ Telephone \_\_\_\_\_  
city state zip

Doctor \_\_\_\_\_ Doctor's Telephone \_\_\_\_\_

<p><b>Allergies</b></p> <table style="width: 100%;"> <tr><td>Penicillin</td><td>Yes</td><td>No</td></tr> <tr><td>Codeine</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Sulfa drug</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Morphine</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Aspirin</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Food Allergies</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Dye allergies</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Nitrate allergies</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>No know allergies</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Pet allergies</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Seasonal (pollen)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>other</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p><b>Used</b></p> <table style="width: 100%;"> <tr><td>Tobacco</td><td>How often?</td></tr> <tr><td>Alcohol</td><td>_____</td></tr> <tr><td>Caffeine</td><td>_____</td></tr> </table>	Penicillin	Yes	No	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drug	<input type="checkbox"/>	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Dye allergies	<input type="checkbox"/>	<input type="checkbox"/>	Nitrate allergies	<input type="checkbox"/>	<input type="checkbox"/>	No know allergies	<input type="checkbox"/>	<input type="checkbox"/>	Pet allergies	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal (pollen)	<input type="checkbox"/>	<input type="checkbox"/>	other	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	How often?	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**Nutritional/Natural Supplements**

Yes	No	What kind?
Vitamins	<input type="checkbox"/>	_____
Minerals	<input type="checkbox"/>	_____
Herbs	<input type="checkbox"/>	_____
Enzymes	<input type="checkbox"/>	_____
Nutritional	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	_____

**Bone Size**      **Bone Type**

Small    Med    Large       Androgenic    Estrogenic

**Family History**

Yes	No	Family Member
Uterine Cancer	<input type="checkbox"/>	_____
Ovarian Cancer	<input type="checkbox"/>	_____
Fibrocystic Breasts	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	_____
Osteoporosis	<input type="checkbox"/>	_____

**Medical History**

Yes	No	Date
Hysterectomy	<input type="checkbox"/>	_____
Ovaries removed	<input type="checkbox"/>	_____
Tubal Ligation	<input type="checkbox"/>	_____

Yes	No	How Many?
Pregnancies	<input type="checkbox"/>	_____
Miscarriages	<input type="checkbox"/>	_____

Have you used \_\_\_\_\_

Yes	No	Any problems
Contraceptives	<input type="checkbox"/>	_____

Have you had any of these tests?

Yes	No	Date
Mammography	<input type="checkbox"/>	_____
PAP Smear	<input type="checkbox"/>	_____

Current Medications	Strength	Date Started	Dosage per day
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____

  

Previous Hormones	Started	Stopped	Reason
1 _____	_____	_____	_____
2 _____	_____	_____	_____
3 _____	_____	_____	_____

**Have you ever had what you consider an abnormal period cycle?**

If so, when? \_\_\_\_\_

Please explain: \_\_\_\_\_

Date of last period \_\_\_\_\_ How long? \_\_\_\_\_

**Do you have or did you ever have PMS?**

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

**Have you experienced any of the following symptoms recently?**

**Please check the number that best describes your experiences.**

**1 = absent, 2 = mild, 3 = moderate, 4 = severe**

Sleep Disruptions	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Weight Gain	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Fatigue	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Decreased Libido	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Vaginal Dryness	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Depression	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Irritability	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Fluid Retention	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Nervousness	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Headaches	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Breast Tenderness	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Night Sweats	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Hot Flashes	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Hair Loss	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Dry Skin	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Hard to Reach Climax	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Mood Swings	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Bladder Symptoms	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Arthritis	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Other: _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4
Loss of Recent Memory	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Other: _____	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4



## HORMONE SELF-TEST

Name \_\_\_\_\_  
last middle first

Today's Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_  
street  
 \_\_\_\_\_  
city state zip

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Telephone \_\_\_\_\_

Doctor \_\_\_\_\_

Doctor's Telephone \_\_\_\_\_

**This is a self-test to help you determine if your hormone levels are below normal. this is designed to help you and your doctor select the correct threatment for you. Check the score for each line then total the score at the bottom of each hormone.**

**0 = Never 1 = Sometimes 2 = Regularly 3 = Often 4 = Constantly**

### Estrogen

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1 I'm losing hair on top of my head                      | 0 | 1 | 2 | 3 | 4 |
| 2 I'm getting thin, vertical wrinkles above my lips      | 0 | 1 | 2 | 3 | 4 |
| 3 My breasts are droopy                                  | 0 | 1 | 2 | 3 | 4 |
| 4 My face is too hairy                                   | 0 | 1 | 2 | 3 | 4 |
| 5 My eyes are dry and easily irritated                   | 0 | 1 | 2 | 3 | 4 |
| 6 I have hot flashes                                     | 0 | 1 | 2 | 3 | 4 |
| 7 I feel tiered constantly                               | 0 | 1 | 2 | 3 | 4 |
| 8 I am depressed   | 0 | 1 | 2 | 3 | 4 |
| 9 My menstrual flow is light (0=moderate/1-3=low/4=none) | 0 | 1 | 2 | 3 | 4 |
| 10 My periods are irregular (<27 days or >31 days)       | 0 | 1 | 2 | 3 | 4 |
| 11 Women without periods. I do not feel like sex anymore | 0 | 1 | 2 | 3 | 4 |

Add up your overall score : \_\_\_\_\_

- 10 or less = satisfactory level
- 11-20 = possible estrogen deficiency
- 21 or more = probably estrogen deficiency

### Progesterone

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1 My breasts are large                               | 0 | 1 | 2 | 3 | 4 |
| 2 My close friends complain I'm nervous and agitated | 0 | 1 | 2 | 3 | 4 |
| 3 I feel anxious                                     | 0 | 1 | 2 | 3 | 4 |
| 4 I sleep lightly and restlessly                     | 0 | 1 | 2 | 3 | 4 |

The following questions are for women who have not yet reached menopause, and menopausal women who are taking hormone replacement therapy (estrogen or estrogen and progesterone)

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 5 My breast are swollen and tender before my period | 0 | 1 | 2 | 3 | 4 |
| 6 And my belly is swollen                           | 0 | 1 | 2 | 3 | 4 |
| 7 And I'm irritable and aggressive                  | 0 | 1 | 2 | 3 | 4 |
| 8 And I lose my self-control                        | 0 | 1 | 2 | 3 | 4 |
| 9 I have heavy periods                              | 0 | 1 | 2 | 3 | 4 |
| 10 And they are continuously painful                | 0 | 1 | 2 | 3 | 4 |

*Post Menopausal women not treated with bhrt*

Add up your overall score : \_\_\_\_\_

- 4 or less = satisfactory level
- 5-8 = possible progesterone deficiency
- 9 or more = probably progesterone deficiency

*Menstrual and Menopausal women taking bhrt*

Add up your overall score : \_\_\_\_\_

- 10 or less = satisfactory level
- 11-20 = possible progesterone deficiency
- 21 or more = probably progesterone deficiency

### Thyroid

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1 I'm sensitive to cold                                      | 0 | 1 | 2 | 3 | 4 |
| 2 My hands and feet are always cold                          | 0 | 1 | 2 | 3 | 4 |
| 3 In the morning my face is fuffy and my eyelids are swollen | 0 | 1 | 2 | 3 | 4 |
| 4 I put on weight easily                                     | 0 | 1 | 2 | 3 | 4 |
| 5 I have dry skin  | 0 | 1 | 2 | 3 | 4 |
| 6 I have trouble getting up in the morning                   | 0 | 1 | 2 | 3 | 4 |
| 7 I feel more tired at rest than when I am active            | 0 | 1 | 2 | 3 | 4 |
| 8 I am constipated   | 0 | 1 | 2 | 3 | 4 |
| 9 My joints are stiff in the morning                         | 0 | 1 | 2 | 3 | 4 |
| 10 I feel like I'm living in slow motion                     | 0 | 1 | 2 | 3 | 4 |

Add up your overall score : \_\_\_\_\_

- 10 or less = satisfactory level
- 11-20 = possible thyroid hormone deficiency
- 21 or more = probably thyroid hormone deficiency

### Pregnenolone

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1 I have memory loss   | 0 | 1 | 2 | 3 | 4 |
| 2 My joints hurt (fingers, wrists, elbows, ankles, knees)                                | 0 | 1 | 2 | 3 | 4 |
| 3 I'm feeling a bit drained and it is hard to handle stress                              | 0 | 1 | 2 | 3 | 4 |
| 4 I don't see colors as brightly as before   | 0 | 1 | 2 | 3 | 4 |
| 5 I have lost interest / appreciation for art  | 0 | 1 | 2 | 3 | 4 |
| 6 I don't have much hair under my arms or pubic area                                     | 0 | 1 | 2 | 3 | 4 |
| 7 I feel more tired at rest than when I am active<br>(0 = plenty of hair / 4 = hairless) | 0 | 1 | 2 | 3 | 4 |
| 8 I have abundant, light-colored urine during the day                                    | 0 | 1 | 2 | 3 | 4 |
| 9 I have low blood pressure  | 0 | 1 | 2 | 3 | 4 |
| 10 I crave salty foods   | 0 | 1 | 2 | 3 | 4 |

Add up your overall score : \_\_\_\_\_

- 10 or less = satisfactory level
- 11-20 = possible pregnenolone deficiency
- 21 or more = probably pregnenolone deficiency

### Melatonin

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1 I look older than I am                                 | 0 | 1 | 2 | 3 | 4 |
| 2 I have trouble falling asleep at night                 | 0 | 1 | 2 | 3 | 4 |
| 3 I wake up during the night...                          | 0 | 1 | 2 | 3 | 4 |
| 4 And I can't get back to sleep                          | 0 | 1 | 2 | 3 | 4 |
| 5 I have anxious thoughts while trying to fall sleep     | 0 | 1 | 2 | 3 | 4 |
| 6 My feet are too hot at night                           | 0 | 1 | 2 | 3 | 4 |
| 7 When I get up, I don't feel rested                     | 0 | 1 | 2 | 3 | 4 |
| 8 I got to be bed late and wake up late                  | 0 | 1 | 2 | 3 | 4 |
| 9 I can't tolerate jet lag                               | 0 | 1 | 2 | 3 | 4 |
| 10 I smoke, drink and/or use a beta/blocker or sleep aid | 0 | 1 | 2 | 3 | 4 |

Add up your overall score : \_\_\_\_\_

- 10 or less = satisfactory level
- 11-20 = possible melatonin deficiency
- 21 or more = probably melatonin deficiency



## HORMONE SELF-TEST

### Testosterone

- |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|
| 1 | My face has gotten slack and more wrinkled        | 0 | 1 | 2 | 3 | 4 |
| 2 | I've lost muscle tone                             | 0 | 1 | 2 | 3 | 4 |
| 3 | My belly tends to get fat                         | 0 | 1 | 2 | 3 | 4 |
| 4 | I'm constantly tired                              | 0 | 1 | 2 | 3 | 4 |
| 5 | I feel like making love less often than I used to | 0 | 1 | 2 | 3 | 4 |

#### The rest of the questions are for men only

- |    |  |   |   |   |   |   |
|----|--|---|---|---|---|---|
| 6  | My breasts are getting fatty                       | 0 | 1 | 2 | 3 | 4 |
| 7  | I feel less self-confident and more hesitant       | 0 | 1 | 2 | 3 | 4 |
| 8  | My sexual performance is poorer than it used to be | 0 | 1 | 2 | 3 | 4 |
| 9  | I have hot flashes and sweats                      | 0 | 1 | 2 | 3 | 4 |
| 10 | I tire easily with physical activity               | 0 | 1 | 2 | 3 | 4 |

For Women: (questions 1-5)

Add up your overall score : \_\_\_\_\_

5 or less = satisfactory level

6-10 = possible testosterone deficiency

11 or more = probably progesterone deficiency

For Men: (questions 1-10)

Add up your overall score : \_\_\_\_\_

10 or less = satisfactory level

11-20 = possible testosterone deficiency

21 or more = probably progesterone deficiency

### Growth Hormone

- |    |   |   |   |   |   |   |
|----|---|---|---|---|---|---|
| 1  | My hair is thinning                                   | 0 | 1 | 2 | 3 | 4 |
| 2  | My cheeks sag   | 0 | 1 | 2 | 3 | 4 |
| 3  | My gums are receding                                  | 0 | 1 | 2 | 3 | 4 |
| 4  | My abdomen is flabby/I've got a "spare tire"          | 0 | 1 | 2 | 3 | 4 |
| 5  | My muscles are slack                                  | 0 | 1 | 2 | 3 | 4 |
| 6  | My skin is thick and/or dry                           | 0 | 1 | 2 | 3 | 4 |
| 7  | It's hard to recover after physical activity          | 0 | 1 | 2 | 3 | 4 |
| 8  | I feel exhausted                                      | 0 | 1 | 2 | 3 | 4 |
| 9  | I don't feel like the world, I tend to isolate myself | 0 | 1 | 2 | 3 | 4 |
| 10 | I feel continuously anxious and worried               | 0 | 1 | 2 | 3 | 4 |

Add up your overall score : \_\_\_\_\_

10 or less = satisfactory level

11-20 = possible growth hormone deficiency

21 or more = probably growth hormone deficiency

### DHEA

- |    |   |   |   |   |   |   |
|----|---|---|---|---|---|---|
| 1  | My hair is dry  | 0 | 1 | 2 | 3 | 4 |
| 2  | My skin and eyes are dry  | 0 | 1 | 2 | 3 | 4 |
| 3  | My muscles are flabby   | 0 | 1 | 2 | 3 | 4 |
| 4  | My belly is getting fat   | 0 | 1 | 2 | 3 | 4 |
| 5  | I don't have much hair under my arm   | 0 | 1 | 2 | 3 | 4 |
| 6  | I don't have much hair in my pubic area<br>( 1 = plenty of hair / 4 = hairless) | 0 | 1 | 2 | 3 | 4 |
| 7  | I don't have much fatty tissue in the pubic area<br>( 0 = padded / 4 = flat)    | 0 | 1 | 2 | 3 | 4 |
| 8  | My body doesn't have much of a special scent during sex                         | 0 | 1 | 2 | 3 | 4 |
| 9  | I can't tolerate noise  | 0 | 1 | 2 | 3 | 4 |
| 10 | My libido is low  | 0 | 1 | 2 | 3 | 4 |

Add up your overall score : \_\_\_\_\_

10 or less = satisfactory level

11-20 = possible DHEA deficiency

21 or more = probably DHEA deficiency

### Cortisol

- |    |   |   |   |   |   |   |
|----|---|---|---|---|---|---|
| 1  | My face looks thinner                     | 0 | 1 | 2 | 3 | 4 |
| 2  | My friends call me "skinny"               | 0 | 1 | 2 | 3 | 4 |
| 3  | I have eczema, psoriasis, or other rashes | 0 | 1 | 2 | 3 | 4 |
| 4  | My heart beats quickly                    | 0 | 1 | 2 | 3 | 4 |
| 5  | My blood pressure is low                  | 0 | 1 | 2 | 3 | 4 |
| 6  | I crave salt or sugar                     | 0 | 1 | 2 | 3 | 4 |
| 7  | I have digestive problems                 | 0 | 1 | 2 | 3 | 4 |
| 8  | I have allergies                          | 0 | 1 | 2 | 3 | 4 |
| 9  | I am stressed out                         | 0 | 1 | 2 | 3 | 4 |
| 10 | I am easily confused                      | 0 | 1 | 2 | 3 | 4 |

Add up your overall score : \_\_\_\_\_

10 or less = satisfactory level

11-20 = possible cortisol deficiency

21 or more = probably cortisol deficiency

### Part II - Circle the answers to the ailments and discuss them with your physician

#### Energy

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Do you have a hard time getting up in the morning?  | Yes                      | No                       |
| Do you always feel tired or tired in the afternoon? | <input type="checkbox"/> | <input type="checkbox"/> |

#### Sex

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Do you lack sexual desire?                         | Yes                      | No                       |
| Does your penis or clitoris seem less sensitive?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your erections not firm enough?                | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you lost your attraction toward your partner? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you lack vaginal lubrication?                   | <input type="checkbox"/> | <input type="checkbox"/> |

#### Sleep

- |                      |                          |                          |
|----------------------|--------------------------|--------------------------|
| Do you sleep poorly? | Yes                      | No                       |
| Do you rarely dream? | <input type="checkbox"/> | <input type="checkbox"/> |

#### Memory

- |                                    |                          |                          |
|------------------------------------|--------------------------|--------------------------|
| Do you suffer from memory loss?    | Yes                      | No                       |
| Do you have trouble concentrating? | <input type="checkbox"/> | <input type="checkbox"/> |

#### Skin and Hair

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Do you have wrinkles along the nose, smile lines or forehead? | Yes                      | No                       |
| Do you have little wrinkles around the eyes and crows feet?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have age spots?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have dry, thin skin?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you losing your hair or is it turning gray?               | <input type="checkbox"/> | <input type="checkbox"/> |

#### Weight Control

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Is your abdomen too plump? Is it distended?                    | Yes                      | No                       |
| Are your breasts too large? Do they get larger before periods? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your buttocks and thighs too well padded, pear shaped?     | <input type="checkbox"/> | <input type="checkbox"/> |

#### Stress and Mood

- |   |                          |                          |
|---|--------------------------|--------------------------|
| Do you suffer from constant fatigue?    | Yes                      | No                       |
| Do you have high blood pressure?        | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you anxious, nervous, or irritable? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do small things set you off?            | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you depressed?                      | <input type="checkbox"/> | <input type="checkbox"/> |

#### Joints and Bones

- |  |                          |                          |
|--|--------------------------|--------------------------|
| Do you have arthritis?   | Yes                      | No                       |
| Do you have osteoarthritis?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have fibromyalgia (sharp shoulder pain)?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you lost muscle mass, tone, and strength?                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have bone loss of the spine, hips, hands, wrists or feet? | <input type="checkbox"/> | <input type="checkbox"/> |