Denver Hormone Health
Dr. Stephen A. Goldstein, MD, FACS
1221 S Clarkson Street, Suite 300
Denver, CO 80210
P: 720.425.9541 F: 720.476.4886

Name*:	DOB*:	Gender*:

(* = REQUIRED INFORMATION)

PATIENT INFORMATION

[MEDICAL HX] [PROVIDER]

PRIMARY RESIDENCE

Address*:			
City*:		State*:	ZIP*:
Phone 1*:	Mobile 1:	Email:	
Phone 2:	Mobile 2:	Fax:	
Soc. Sec.:	Status:	Spouse/Partner:	
Contact Preference(s): ☐ Email ☐ Mail ☐ Phone ☐ Mobile ☐ Home ☐ Work		Best time(s) to contact you:	
Where did you hear about us?			

SECONDARY RESIDENCE

Address:			
City:		State:	ZIP:
Phone:	Mobile:	Email:	

WORK

Employer:		Occupation:	
Address:			
City:		State:	ZIP:
Phone:	Mobile:	Email:	

INSURANCE

☐ Complete this section only if box is checked

Person responsible for bill:		DOB:	Gender:
Patient's relationship to person responsible for bill: ☐ Self ☐ Spouse ☐ Other:			
Address:			
City:		State:	ZIP:
Phone:	Fax:	Email:	
Soc. Sec.:	Is patient covered by insurance? ☐ Yes ☐ No		
Primary Insurance:		Secondary Insurance:	
Group no.	Policy no.:	Co-payment: $	

EMERGENCY CONTACT

Name:		Relationship:	
Address:			
City:		State:	ZIP:
Phone:	Mobile:	Email:	
Your Primary Care Provider:		Phone:	Fax:

PATIENT CONSENT FOR MEDICAL SERVICES and FINANCIAL OBLIGATIONS

The Business Name listed above will be referred to as the 'BUSINESS' in this document. The Provider Name listed above will be referred to as the 'PROVIDER' in this document.

PATIENT and the PROVIDER hereby enter into this agreement for provision of medical services specified herein (SERVICES). Wherefore, in exchange for consideration, the receipt and sufficiency of which the parties hereby acknowledge the PATIENT and PROVIDER agree as follows:

1. The PATIENT acknowledges and agrees that this agreement has been entered into before the PROVIDER has provided the SERVICES specified herein to the PATIENT.
2. The PATIENT acknowledges and agrees that this agreement has not been entered into at a time when the PATIENT is facing an emergency or an urgent health care situation.
3. The PATIENT acknowledges reading and having access to a copy of the Notice of Privacy Practices, and by signing this agreement, the PATIENT authorizes the BUSINESS and its representatives to use and share PATIENT health information as described in the Notices of Privacy Practices.
4. The SERVICES provided to the PATIENT may include, but not be limited to:
    a. Evaluation of patient medical history, lifestyle, laboratory and other test results recommended by the PROVIDER;
    b. Physical examination and diagnostic tests;
    c. Medical recommendations and management of the aging processes for disease prevention and healthy aging, which may include some or all of the following: nutrition, nutritional supplementation, exercise, lifestyle behaviors, stress management, hormone replacement therapy, and other interventions as indicated by medical history, physical examination and/or laboratory parameters.
5. The PATIENT agrees to be fully responsible for all costs of the SERVICES. All costs are to be paid in full by the PATIENT to the PROVIDER in accordance with any signed Consultation or Retainer Service Agreements between the PATIENT and PROVIDER.

By signing this agreement, the PATIENT acknowledges that PATIENT has read and fully understands the information contained in this agreement, and agrees and consents to the obligations herein listed.

Patient Signature*:	Date*: Click date

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MEDICAL HISTORY

INSTRUCTIONS: COMPLETE EACH SECTION AS COMPLETELY, AND CANDIDLY, AS POSSIBLE. READ INSTRUCTIONS THOROUGHLY PRIOR TO COMPLETING SECTIONS. ENTER INFORMATION IN THE GRAY HIGHLIGHTED FIELDS, OR CHECK BOXES. USE THE TAB KEY ON YOUR KEYBOARD TO NAVIGATE TO THE TEXT FIELD OR THE NEXT SECTION, OR JUST CLICK IN A FIELD TO ENTER TEXT. DO NOT USE THE ENTER KEY. ITEMS MARKED WITH AN (*) ARE REQUIRED, IF APPLICABLE.

MY PRIMARY HEALTH CONCERNS / GOALS

☐ CHECK IF NONE — CURRENT MEDICAL PROBLEMS

☐ CHECK IF NONE — ALLERGIES

☐ CHECK IF NONE — MEDICATION SENSITIVITIES / REACTIONS

☐ CHECK IF NONE — CURRENT MEDICATIONS - PRESCRIPTION & NON-PRESCRIPTION (name/dose/reason for taking) [☑] [☑] [>]

☐ CHECK IF NONE — CURRENT SUPPLEMENTS (name/dose/reason for taking) [☑] [>]

☐ CHECK IF NONE — IMMUNIZATIONS [☑] [>]

Immunization	Year of Last	Immunization	Year of Last
TETANUS/TD		PNEUMONIA	
INFLUENZA (FLU)		HEPATITIS	
OTHER:		VARICELLA	

☐ CHECK IF NONE — SCREENING TESTS [☑] [>]

Screen	Date	Results?	Screen	Date	Results?
CHOLESTEROL/LIPIDS			DENTAL EXAM		
BLOOD SUGAR			EYE EXAM		
PAP SMEAR			SKIN EXAM		
MAMMOGRAM			COLONOSCOPY		
BONE DENSITY			PSA (PROSTATE TEST)		
VASCULAR ULTRASOUND			PROSTATE EXAM		

☐ CHECK IF NONE — HOSPITAL ADMISSIONS / SURGERIES (Not including pregnancies)

Year	Illness/Operation	Year	Illness/Operation
	TOTAL HYSTERECTOMY (removal of uterus + both ovaries)		
	BILATERAL OOPHORECTOMY (removal of both ovaries)		

FAMILY HISTORY

INSTRUCTIONS: CHECK BOXES IF A BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING –INDICATE WHICH RELATIVE(S), AND GIVE DETAILS

1. ☐ ANEMIA	2. ☐ ALCOHOLISM	3. ☐ ALZHEIMER'S	4. ☐ ARTHRITIS
5. ☐ ASTHMA	6. ☐ BLEEDS EASILY	7. ☐ CANCER (TYPE)	8. ☐ DIABETES
9. ☐ EPILEPSY	10. ☐ GLAUCOMA	11. ☐ HAY FEVER	12. ☐ HEART DISEASE
13. ☐ HEPATITIS	14. ☐ HYPERTENSION	15. ☐ LIPID DISORDER	16. ☐ MENTAL ILLNESS
17. ☐ OSTEOPOROSIS	18. ☐ STROKE	19. ☐ THYROID DX	20. ☐

HAS YOUR MOTHER HAD A HIP FRACTURE AFTER AGE 50?: ☐ YES ☐ NO

FAMILY HISTORY DETAILS (INDICATE THE NUMBER ABOVE, WHICH RELATIVE(S) AND BRIEF EXPLANATION IF NEEDED):

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PERSONAL MEDICAL HISTORY

INSTRUCTIONS: FOR CURRENT/ONGOING PROBLEMS, ENTER: 1 = MILD; 2 = MODERATE; 3 = SEVERE; P = PAST PROBLEMS NOT CURRENTLY AFFECTING YOU.

	DECREASED HEARING		AIDS / HIV
	RINGING IN EAR		THYROID DISEASE
	EAR INFECTIONS – FREQUENT		ABDOMINAL PAIN - CHRONIC
	DIZZY SPELLS		GALL BLADDER TROUBLE
	FAINTING SPELLS		JAUNDICE / HEPATITIS
	FAILING VISION		HAVE _____ BOWEL MOVEMENTS EVERY DAY
	EYE PAIN		FREQUENT: ☐ CONSTIPATION ☐ DIARRHEA
	DOUBLE OR BLURRED VISION		DIVERTICULOSIS
	NOSE BLEEDS – RECURRENT		CROHN'S / COLITIS
	SINUS TROUBLE		BLOODY OR TARRY STOOLS
	SORE THROATS – FREQUENT		HEMORRHOIDS
	HOARSENESS – PROLONGED		HERNIA; TYPE-
	DENTAL PROBLEMS:		URINATION – OVERACTIVE BLADDER/ URGENCY TO URINATE
	FLOSS TEETH ___ TIMES PER WEEK		DECREASE IN URINARY FORCE/FLOW
	HAY FEVER / ALLERGIES		PAINFUL URINATION
	PNEUMONIA / PLEURISY		URINE LEAKAGE WITH: EXERCISE/STRAINING/COUGH
	BRONCHITIS / CHRONIC COUGH		BLOOD IN URINE
	SHORTNESS OF BREATH: ☐ EXERTIONAL ☐ LYING FLAT		KIDNEY STONES
	ASTHMA / WHEEZING		URINE INFECTIONS – FREQUENT
	CHEST PAIN		SEXUALLY TRANSMITTED DISEASES:
	HIGH BLOOD PRESSURE		RECENT WEIGHT- ☐ GAIN ☐ LOSS: _____ LBS.
	HEART MURMUR		DESIRED WEIGHT: LBS.
	RAPID HEART BEAT		ANEMIA
	SWOLLEN ANKLES		BRUISE EASILY
	IRREGULAR PULSE		BLOOD TRANSFUSIONS
	PALPITATIONS		CANCER; TYPE(S)-_____
	LEG PAIN – WHEN WALKING		CHRONIC FATIGUE
	VARICOSE VEINS / PHLEBITIS		DIABETES
	COLD NUMB FEET		SEIZURES
	LOSS OF APPETITE – RECENT		STROKE
	DIFFICULTY SWALLOWING		TREMOR / HANDS SHAKING
	HEARTBURN		NUMBNESS / TINGLING SENSATIONS
	PEPTIC ULCER		HEADACHES – FREQUENT
	PERSISTENT NAUSEA / VOMITING		ARTHRITIS; TYPE/LOCATION:_____
	BONE FRACTURE / JOINT INJURY		BACK PAIN – RECURRENT
	FRACTURES AFTER AGE 50? ☐YES ☐NO		CUPS/DAY: ☐ COFFEE- ☐ TEA-
	FOOT PAIN		ALCOHOL: ☐NEVER ☐RARELY ☐WEEKLY ☐DAILY;# DRINKS: PER
	OSTEOPOROSIS		☐BEER ☐WINE ☐LIQUOR
	GOUT		GOTTEN DRUNK IN THE PAST MONTH? ☐ YES ☐ NO
	RASHES		FELT THE NEED TO STOP DRINKING? ☐ YES ☐ NO
	HIVES		SMOKING:# CIGARS/CIGARETTES PER X YRS.
	PSORIASIS		YEAR QUIT SMOKING:
	ECZEMA		RECREATIONAL DRUGS:
	SLEEPING DIFFICULTY		☐ ACUPUNCTURE; ☐ TATTOOS
	CONCENTRATION DIFFICULTY		ABUSE: ☐ PHYSICAL ☐ SEXUAL ☐ OTHER
	DEPRESSION		HAIR LOSS: ☐ PROGRESSIVE ☐ RECENT
	NERVOUSNESS		DO YOU HAVE A LACK OF ENERGY?
	AGITATION		DO YOU HAVE LESS STRENGTH/ENDURANCE?
	MEMORY LOSS		HAVE YOU LOST HEIGHT? INCHES
	MOODINESS		DECREASED "ENJOYMENT OF LIFE?"
	SUICIDAL THOUGHTS		ARE YOU SAD AND/OR GRUMPY?
	PHOBIAS		RECENT DETERIORATION IN ABILITY TO PLAY SPORTS?
	MENTAL ILLNESS		ARE YOU FALLING ASLEEP AFTER DINNER?
	FEELINGS OF WORTHLESSNESS		RECENT DETERIORATION IN WORK PERFORMANCE?
	RHEUMATIC FEVER		DO YOU HAVE A DECREASE IN LIBIDO?
	SCARLET FEVER		SATISFIED WITH ORGASM FREQUENCY? ☐ YES ☐ NO
	CHICKEN POX		ARE YOU SEXUALLY ACTIVE? PAST CURRENT
	POLIO		OPPOSITE SEX ☐ ☐
	MUMPS		SAME SEX ☐ ☐
	GERMAN MEASLES		SINGLE PARTNER ☐ ☐
	TUBERCULOSIS		MULTIPLE PARTNERS ☐ ☐
	HERPES		# OF SEX PARTNERS IN PAST YEAR:___

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FEMALES (complete this section)

☐ IT HAS BEEN AT LEAST 12 MONTHS SINCE MY LAST PERIOD | ☐ I AM PREGNANT

DATE OF THE 1ST DAY OF YOUR LAST | PERIODS START EVERY DAYS; # DAYS OF FLOW: | DATE OF THE 1ST DAY OF YOUR LAST PERIOD:

AGE WHEN YOU STARTED PERIODS: | PAIN / BLEEDING DURING OR AFTER SEX: ☐ YES ☐ NO | AGE WHEN YOU STARTED PERIODS:

NUMBER OF PREGNANCIES: | # OF LIVE BIRTHS: | # OF ABORTIONS: | # OF MISCARRIAGES: | AGE AT 1ST DELIVERY:

HOW DO/DID YOU FEEL DURING DIFFERENT DAYS OF THE MONTH OF YOUR CYCLE?

HOW DO/DID YOU FEEL A FEW DAYS BEFORE AND DURING THE PERIOD?

HOW DO/DID YOU FEEL FROM THE DAY OF OVULATION TO THE ONSET OF HEAVY FLOW?

DID YOU DEVELOP SIGNS OF DEFICIENCY AFTER STARTING BIRTH CONTROL PILLS? | DID YOU FEEL BETTER AFTER STARTING BIRTH CONTROL PILLS?

DID YOU FEEL MISERABLE, GAIN WEIGHT OR DID BREAST SIZE INCREASE AFTER STARTING BIRTH CONTROL PILLS?

MALES (complete this section)

ENTER A SEVERITY SCORE (0-4) FOR SYMPTOMS YOU CURRENTLY EXPERIENCE: **BLANK= NONE, 1 = MILD, 2 = MODERATE, 3 = SEVERE, 4 = EXTREME**		ENTER A FREQUENCY SCORE (1-5) FOR SYMPTOMS YOU'VE HAD IN THE PAST MONTH: **BLANK = NOT AT ALL; 1 = LESS THAN 1 TIME 5; 2 = LESS THAN HALF THE TIME; 3 = HALF THE TIME; 4 = MORE THAN HALF THE TIME; 5 = ALMOST ALWAYS**	
DECLINE IN YOUR FEELING OF GENERAL WELL-BEING		HAD SENSATION OF NOT EMPTYING BLADDER COMPLETELY AFTER URINATING?	
JOINT PAIN AND MUSCULAR ACHE		HAD TO URINATE AGAIN LESS THAN 2 HOURS AFTER URINATING?	
EXCESSIVE SWEATING		STOPPED AND STARTED URINATING SEVERAL TIMES?	
SLEEP PROBLEMS		FOUND IT DIFFICULT TO POSTPONE URINATION?	
INCREASED NEED FOR SLEEP, OFTEN FEELING TIRED		HAD A WEAK URINARY STREAM?	
IRRITABILITY		HAD TO PUSH OR STRAIN TO BEGIN URINATING?	
NERVOUSNESS		TYPICALLY UP TO URINATE FROM BEDTIME TO GETTING UP?	
ANXIETY		HAD SENSATION OF NOT EMPTYING BLADDER COMPLETELY AFTER URINATING?	
PHYSICAL EXHAUSTION / LACK VITALITY			
DECREASE IN MUSCULAR STRENGTH			
DEPRESSIVE MOOD			
FEELING THAT YOU HAVE PASSED YOUR PEAK			
FEELING BURNT OUT, HAVING HIT ROCK BOTTOM			
DECREASE IN BEARD GROWTH			
DECREASE IN ABILITY / FREQUENCY TO PERFORM SEXUALLY			
DECREASE IN THE NUMBER OF MORNING ERECTIONS			
DECREASE IN SEXUAL DESIRE / LIBIDO			

ADRENAL

INSTRUCTIONS: ENTER A RATING (0-3) FOR EACH STATEMENT BELOW THAT APPLIES TO YOU
BLANK = NEVER/RARELY; 1 = OCCASIONALLY/SLIGHTLY; 2 = MODERATE INTENSITY OR FREQUENCY; 3 = INTENSE/SEVERE OR FREQUENT

	I HAVE EXPERIENCED LONG PERIODS OF STRESS THAT HAVE AFFECTED MY WELL-BEING
	I HAVE HAD ONE OR MORE SEVERELY STRESSFUL EVENTS THAT HAVE AFFECTED MY WELL-BEING
	I HAVE DRIVEN MYSELF TO EXHAUSTION
	I OVERWORK WITH LITTLE PLAY OR RELAXATION FOR EXTENDED PERIODS
	I HAVE HAD EXTENDED, SEVERE OR RECURRING RESPIRATORY INFECTIONS
	I HAVE TAKEN LONG TERM OR INTENSE STEROID THERAPY (CORTICOSTEROIDS)
	I TEND TO GAIN WEIGHT, ESPECIALLY AROUND THE MIDDLE (SPARE TIRE)
	I HAVE A HISTORY OF ALCOHOLISM AND/OR DRUG ABUSE
	I HAVE ENVIRONMENTAL SENSITIVITIES
	I HAVE DIABETES (TYPE II, ADULT ONSET, NIDDM)
	I SUFFER FROM POST-TRAUMATIC DISTRESS SYNDROME
	I SUFFER FROM ANOREXIA
	I HAVE ONE OR MORE OTHER CHRONIC ILLNESSES OR DISEASES
	MY ABILITY TO HANDLE STRESS AND PRESSURE HAS DECREASED
	I AM LESS PRODUCTIVE AT WORK
	I SEEM TO HAVE DECREASED IN COGNITIVE ABILITY. I DO NOT THINK AS CLEARLY AS I USED TO
	MY THINKING IS CONFUSED WHEN HURRIED OR UNDER PRESSURE
	I TEND TO AVOID EMOTIONAL SITUATIONS
	I TEND TO SHAKE OR AM NERVOUS WHEN UNDER PRESSURE
	I SUFFER FROM NERVOUS STOMACH INDIGESTION WHEN TENSE
	I HAVE MANY UNEXPLAINED FEARS/ANXIETIES
	MY SEX DRIVE IS NOTICEABLY LESS THAN IT USED TO BE
	I GET LIGHTHEADED OR DIZZY WHEN RISING RAPIDLY FROM A SITTING OR LYING POSITION
	I HAVE FEELINGS OF GRAYING OUT OR BLACKING OUT
	I FEEL UNWELL MUCH OF THE TIME
	I NOTICE THAT MY ANKLES ARE SOMETIMES SWOLLEN – AND IS WORSE IN THE EVENING
	I USUALLY NEED TO LIE DOWN OR REST AFTER TIMES OF PSYCHOLOGICAL OR EMOTIONAL PRESSURE/STRESS
	MY MUSCLES SOMETIMES FEEL WEAKER THAN THEY SHOULD
	MY HANDS AND LEGS GET RESTLESS – EXPERIENCE MEANINGLESS BODY MOVEMENTS
	I HAVE BECOME ALLERGIC OR HAVE INCREASED FREQUENCY/SEVERITY OF ALLERGIC REACTIONS

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	SMALL IRREGULAR DARK BROWN SPOTS HAVE APPEARED ON MY FOREHEAD, FACE, NECK AND SHOULDERS
	WHEN I SCRATCH MY SKIN, A WHITE LINE REMAINS FOR A MINUTE OR MORE
	I HAVE UNEXPLAINED AND FREQUENT HEADACHES
	I AM FREQUENTLY COLD
	I OFTEN BECOME HUNGRY, CONFUSED, SHAKY OR SOMEWHAT PARALYZED UNDER STRESS
	I HAVE LOST WEIGHT WITHOUT REASON WHILE FEELING VERY TIRED AND LISTLESS
	I HAVE FEELINGS OF HOPELESSNESS OR DESPAIR
	I HAVE DECREASED TOLERANCE. PEOPLE IRRITATE ME MORE
	THE LYMPH NODES (GLANDS) IN MY NECK ARE FREQUENTLY SWOLLEN
	I OFTEN HAVE TO FORCE MYSELF IN ORDER TO KEEP GOING. EVERYTHING SEEMS LIKE A CHORE
	I AM EASILY FATIGUED
	I HAVE DIFFICULTY GETTING UP IN THE MORNING (DON'T REALLY WAKE UP UNTIL ABOUT 10 AM)
	I SUDDENLY RUN OUT OF ENERGY
	I USUALLY FEEL MUCH BETTER AND FULLY AWAKE AFTER THE NOON MEAL
	I OFTEN HAVE AN AFTERNOON LOW BETWEEN 3 – 5 PM
	I GET LOW ENERGY, MOODY OR FOGGY IF I DO NOT EAT REGULARLY
	I USUALLY FEEL MY BEST AFTER 6 PM
	I AM OFTEN TIRED AT 9-10 PM, BUT RESIST GOING TO BED
	I LIKE TO SLEEP LATE IN THE MORNING
	MY BEST, MOST REFRESHING SLEEP OFTEN COMES BETWEEN 7-9 AM
	I OFTEN DO MY BEST WORK LATE AT NIGHT (EARLY IN THE MORNING)
	IF I DON'T GO TO BED BY 11 PM, I GET A SECOND BURST OF ENERGY AROUND 11 PM, OFTEN LASTING UNTIL 1-2 AM
	I GET COUGHS/COLDS THAT STAY AROUND FOR SEVERAL WEEKS
	I HAVE FREQUENT OR RECURRING BRONCHITIS, PNEUMONIA OR OTHER RESPIRATORY INFECTIONS
	I GET ASTHMA, COLDS AND OTHER RESPIRATORY INVOLVEMENT TWO OR MORE TIMES PER YEAR
	I FREQUENTLY GET RASHES, DERMATITIS, OR OTHER SKIN CONDITIONS
	I HAVE RHEUMATOID ARTHRITIS
	I HAVE ALLERGIES TO SEVERAL THINGS IN THE ENVIRONMENT
	I HAVE MULTIPLE CHEMICAL SENSITIVITIES
	I HAVE CHRONIC FATIGUE SYNDROME
	I GET PAIN IN THE MUSCLES OF MY UPPER BACK AND LOWER NECK FOR NO APPARENT REASON
	I GET PAIN IN THE MUSCLES ON THE SIDES OF MY NECK
	I HAVE INSOMNIA OR DIFFICULTY SLEEPING
	I HAVE FIBROMYALGIA
	I SUFFER FROM ASTHMA
	I SUFFER FROM HAY FEVER
	I SUFFER FROM NERVOUS BREAKDOWNS
	MY ALLERGIES ARE BECOMING WORSE (MORE SEVERE, FREQUENT OR DIVERSE)
	THE FAT PADS ON PALMS OF MY HANDS AND/OR TIPS OF MY FINGERS ARE OFTEN RED
	I HAVE A TENDERNESS IN MY BACK NEAR MY SPINE AT THE BOTTOM OF MY RIB CAGE WHEN PRESSED
	I BRUISE MORE EASILY THAN I USED TO
	I NEED COFFEE OR SOME OTHER STIMULANT TO GET GOING IN THE MORNING
	I HAVE SWELLING UNDER MY EYES UPON RISING THAT GOES AWAY AFTER I HAVE BEEN UP FOR A COUPLE OF HOURS
	I OFTEN CRAVE FOOD HIGH IN FAT AND FEEL BETTER WITH HIGH FAT FOODS
	I USE HIGH FAT FOODS TO DRIVE MYSELF
	I OFTEN USE HIGH FAT FOODS AND CAFFEINE CONTAINING DRINKS (COFFEE, COLAS, CHOCOLATE) TO DRIVE MYSELF
	I OFTEN CRAVE SALT AND/OR FOODS HIGH IN SALT. I LIKE SALTY FOODS
	I FEEL WORSE AFTER HIGH POTASSIUM FOODS (E.G. BANANAS, FIGS, RAW POTATOES), ESP. IF EATEN IN THE MORNING
	I CRAVE HIGH PROTEIN FOODS (MEATS, CHEESES)
	I CRAVE SWEET FOODS (PIES, CAKES, PASTRIES, DOUGHNUTS, DRIED FRUITS, CANDIES OR DESSERTS)
	I FEEL WORSE IF I MISS OR SKIP A MEAL
	I HAVE CONSTANT STRESS IN MY LIFE OR WORK
	MY DIETARY HABITS TEND TO BE SPORADIC AND UNPLANNED
	MY RELATIONSHIPS AT WORK AND/OR HOME ARE UNHAPPY
	I DO NOT EXERCISE REGULARLY
	I EAT LOTS OF FRUIT
	MY LIFE CONTAINS INSUFFICIENT ENJOYABLE ACTIVITIES
	I HAVE LITTLE CONTROL OVER HOW I SPEND MY TIME
	I RESTRICT MY SALT INTAKE
	I HAVE GUM AND/OR TOOTH INFECTIONS OR ABSCESSES
	I HAVE MEALS AT IRREGULAR TIMES
	I FEEL BETTER ALMOST RIGHT AWAY ONCE A STRESSFUL SITUATION IS RESOLVED
	REGULAR MEALS DECREASE THE SEVERITY OF MY SYMPTOMS
	I OFTEN FEEL BETTER AFTER SPENDING A NIGHT OUT WITH FRIENDS
	I OFTEN FEEL BETTER IF I LIE DOWN

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	OTHER RELIEVING FACTORS: ____
	I AM CHRONICALLY FATIGUED; A TIREDNESS THAT IS NOT USUALLY RELIEVED BY SLEEP
	I SOMETIMES FEEL WEAK ALL OVER
	I HAVE DECREASED TOLERANCE FOR COLD
	I HAVE TIMES OF NAUSEA AND VOMITING FOR NO APPARENT REASON
	I HAVE LOW BLOOD PRESSURE
	FEMALE: SYMPTOMS OF PREMENSTRUAL SYNDROME (PMS): CRAMPS, BLOATING, MOODINESS, IRRITABILITY, EMOTIONAL INSTABILITY, HEADACHES, TIREDNESS,
	FEMALE: MY PERIODS ARE HEAVY BUT OFTEN (ALMOST) STOP ON THE 4TH DAY, & START UP PROFUSELY ON THE 5TH OR 6TH DAY

ENTER THE DIGIT 1 FOR EACH OF THE FOLLOWING SIGNS OR SYMPTOMS THAT APPLY TO YOU

ANY AREAS THAT HAVE BECOME BLUISH-BLACK COLOR?: INSIDE LIPS/MOUTH, VAGINA, AROUND NIPPLES

	INCREASED DARKENING AROUND BONY AREAS, AT SKIN FOLDS, SCARS AND IN JOINT CREASES?	
	LIGHT COLORED PATCHES ON SKIN WHERE IT HAS LOST ITS USUAL COLOR?	FAINTING SPELLS?
	FREQUENT UNEXPLAINED DIARRHEA?	EASILY BECOME DEHYDRATED?

HORMONE SIGNS & SYMPTOMS

INSTRUCTIONS: ENTER A SEVERITY SCORE TO ALL SYMPTOMS YOU CURRENTLY EXPERIENCE: **BLANK = NONE; 1 = MILD; 2 = MODERATE; 3 = SEVERE; 4 = EXTREME**

ARTHRITIS/STIFFNESS		SKIN – DRY	
JOINT OR BACK PAIN		SKIN - OILY	
OSTEOPOROSIS		SKIN - WRINKLES	
MUSCLE FLABBINESS OR WEAKNESS		EXCESSIVE SWEATING	
WEIGHT – GAIN		ANXIETY	
WEIGHT – LOSS		DEPRESSION	
HEADACHES		IRRITABILITY	
BLOOD PRESSURE - LOW		MOOD SWINGS	
BLOOD PRESSURE - HIGH		DECREASED LIBIDO	
HEART PALPITATION		DECREASED SENSE OF SEXUALITY	
DROWSINESS		DECREASED SEXUAL AROUSABILITY	
INSOMNIA/SLEEP DISTURBANCES		HARDER TO REACH CLIMAX	
FATIGUE		AMENORRHEA (NO PERIOD)	
FORGETFULNESS		BREAKTHROUGH BLEEDING	
HEAT INTOLERANCE		CRAMPS	
SENSITIVE TO TEMP. SWINGS		ENDOMETRIOSIS, FIBROIDS, ADENOMYOSIS	
TEMPERATURE SWINGS		HEAVY/IRREGULAR PERIODS	
TEMPERATURE LOW		BREASTS - FIBROCYSTIC	
DIZZINESS		BREASTS - SAGGING/LESS FULLNESS	
FOOD CRAVINGS		BREASTS - TENDERNESS	
DIARRHEA		BREASTS - SIZE INCREASED/FULLNESS	
BLADDER SYMPTOMS		HOT FLASHES	
ACNE		NIGHT SWEATS	
HAIR - DRY		NIPPLE TENDERNESS	
HAIR – FACIAL		PMS (PREMENSTRUAL SYNDROME)	
HAIR – LOSS: SCALP		VAGINAL DRYNESS	
HAIR – LOSS: PUBIC, ARMPIT & BODY		WATER RETENTION/BLOATING	
		ERECTION PROBLEMS	

NUTRITION

INSTRUCTIONS: LIST DIETS YOU HAVE BEEN ON DURING THE PAST 12 MONTHS, ALONG WITH REASON(S) FOR FOLLOWING IT, BENEFITS OR PROBLEMS YOU EXPERIENCED WITH IT, AND THE REASON(S) FOR STOPPING ANY DIET:

CURRENT EXERCISE(S)

CURRENT SOURCE(S) OF STRESS

ADDITIONAL INFORMATION YOU WISH TO SHARE WITH YOUR PROVIDER

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PROVIDER USE ONLY

[PT INFO] [MEDICAL HX] [?]

PROVIDER INSTRUCTIONS (Follow steps sequentially):

1. Click **BOTH** check boxes: ☐ ☐
2. Click the ☑s below, to get Score Classifications. Enter Classification in the adjacent drop-down fields.
3. Click the item name review the related questions in the questionnaire
4. CLICK HERE for information management options

RATIO SCORE:	HI	LO	FLUC	☑ CLASSIFICATION
ESTROGEN	0.00	0.00	0.00	
PROGESTERONE	0.00	0.00	--	
DHEA	0.00	0.00	--	
TESTOSTERONE	0.00	0.00	--	
THYROID	0.00	0.00	--	
CORTISOL	0.00	0.00	--	
HGH	--	0.00	--	

	SCORE	CLASSIFICATION
MENOPAUSE ☑		
ANDROPAUSE ☑	0	
ADRENAL ☑	TOTAL: 0	(*) TOTAL: 0 (**) #: 0
BPH ☑	0	

PROVIDER COMMENTS / DISCUSSION

[TEMPLATE]