GRAMERCY PARK INTEGRATIVE
DR. DLADLA

Female Hormone Intake Form

Personal Information

Name	**Date of Birth**	**Vitals** **BP:** **Pulse:** **Weight:**
Street Address	**City, Province, Postal Code**	**Best Phone to Reach You**
Cell Phone	**Can We Leave A Message? (yes or no)**	**Email**
Allergies: (Meds/Environmental/Latex)	**Occupation**	**Spouse / Partner**
Emergency Contact/Phone	**Primary Care Physician**	**Referred By**

Past Medical Hx: _____

_____

_____

Past Surgical Hx: _____

_____

CURRENT MEDICATIONS

Name of Medication	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

CURRENT SUPPLEMENTS (Vitamins, Minerals, Herbs, etc.)

Name of Supplement	Dose Milligrams or Micrograms	# of Pills Daily	Date Started

PREVIOUS SURGERIES

Surgery / Procedure	Date

MEDICAL CARE	DATE	RESULTS OR FINDINGS
Physical Exam		
Gynecological Exam		
Bone Density		
Colonoscopy		
Mammography		
Cardiac Test (EKG, Echo, Stress, etc.)		

DIET AND LIFESTYLE

List dietary restrictions or food allergies:

Describe typical meals:	
Breakfast	
Lunch	
Dinner	
Snacks	

HABITS (please check)	Yes	No	Amount / Type
Do you get regular exercise?			
Do you consume alcohol?			
Do you smoke?			
Experience excessive stress?			

SLEEP HEALTH			WEEKDAYS/WEEKENDS
What time do you get in Bed?			
What time do you fall asleep?			
What time do you wake up?			
Is your sleep interrupted, how often?	YES	NO	
Do you have a TV in your room?	YES	NO	

GYNECOLOGICAL HISTORY

Age Started Menstruation:	Date of Last Menstrual Cycle:	Age Stopped If Applicable:
Hysterectomy? Yes: ____ No: ____	Do you have ovaries: Yes:_____ No:_____	Reason for Hysterectomy:
Are your periods regular? Yes: _____ No: ____NA	How many days do your cycles last?	Are your cycles heavy? Yes: ____ No: ____ NA
Bleeding between periods? Yes: _____ No: ____ NA	Do you have painful periods? Yes:_____ No_____ NA	Endometriosis? Yes: _____ No: _____
Number of Pregnancies:	Have you had a miscarriage? Yes: _____ No: _____	Do you have PMS symptoms? Yes: _____ No: _____ NA

HORMONE USAGE

Do you take hormones of any kind? Yes_____ No_____ If so, list (include birth control pills, HRT, or natural hormone (s):

Brand	Dose	How Often	Date Started

If you are currently taking hormones, what specific symptoms are improved? Please list:

_____

_____

If you are currently taking hormones, are you experiencing any unwanted side effects?
Please list:

_____

_____

Are you familiar with bioidentical hormones? Yes_____ No_____

Have you tried other hormones? Yes: _____ No: _____ If yes, list below:

Brand	Dose	How Often	Date Started	Reason Stopped

HORMONE RELATED SYMPTOMS
Current Symptoms – mark severity of symptoms that apply to you.

Symptom	**Mild**	**Moderate**	**Severe**
Hot Flashes			
Night Sweats			
Vaginal Dryness			
Painful Intercourse			
Incontinence			
Foggy Thinking			
Tearfulness			
Depression			
Heart Palpitations			
Bone Loss			
Sleep Disturbances			
Headaches			
Aches and Pains			
Fibromyalgia			
Morning Fatigue			
Afternoon Fatigue			
Allergies			
Chemical Sensitivities			
Sugar Cravings			
Salty Cravings			
Weight gain- waist			
Decreased Libido			
Loss of Scalp Hair			

Increased Face or Body Hair			
Cystic Ovaries			
Acne			
Mood Swings			
Breast Tenderness			
PMS			
Bleeding Changes			
Nervousness			
Irritability			
Anxiousness			
Water Retention			
Fibrocystic Breasts			
Uterine Fibroids			
Weight Gain - Hips			
Decreased Stamina			
Decreased Muscle Size			
Rapid Aging			
High Cholesterol			
Puffy Eyes / Face			
Slow Pulse			
Decreased Sweating			
Hair Dry or Brittle			
Nails Breaking /Brittle			
Thinning Skin			
Infertility			
Constipation			
Rapid Heart Beat			
Goiter			
Hoarseness			
Increased Urinary Urge			
Low Blood Sugar			
High Blood Pressure			
Low Blood Pressure			
Numbness – Feet / Hands			

Patient Signature _____ Date _____
Provider signature_____ Date _____