



Female Hormone Evaluation History

Name (As it appears on your OHIP card): _____
 Address: _____ City: _____ Postal: _____
 Phone (H): _____ (B): _____ (C): _____
 OHIP# _____ DOB: (DD/MM/YYYY) _____
 Email: _____ Height: _____ Weight: _____

I understand and accept the fee schedule of \$100 a year (initial year being \$150) and the 24-hour cancellation policy of the Taunton Chiropractic and Health Centre.

Signature: _____ Date: _____

Medical History:

Do you use: (How much and how often)

Tobacco? Y/N _____
 Alcohol? Y/N _____
 Caffeine? Y/N _____

Doctor's Name: _____ Address: _____ Phone: _____

Allergies: (check all that apply)

Penicillin Morphine Dye Pets Codeine Aspirin
 Nitrates Seasonal(pollen) Sulfa Drugs Foods Other None

Please describe allergic reaction: _____

Over the Counter (OTC) issues:

Please check all products that you use occasionally or regularly.

Pain reliever Aspirin Acetaminophen(Tylenol) Ibuprofen(Advil)
 Naproxen(Aleve) Ketoprofen(Orudis) Cough Suppressant Antihistamine
 Decongestant Sleep Aids(Nytol) Antidiarrheals Laxatives/Stool Softeners
 Diet aids Antacids Acid blockers(Zantac)

Others (please list): _____

Nutritional/Natural Supplements (Please list products you are using)

Vitamins (eg B Complex): _____
 Minerals (eg. Calcium): _____
 Herbs (eg. Echinacea): _____
 Enzymes (eg. Co-enzyme Q10): _____
 Protein (eg Fish oils): _____
 Others (glucosamine): _____



**TAUNTON CHIROPRACTIC
AND HEALTH CENTRE**

Medical Conditions/Diseases (check all that apply)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ulcers (Stomach) | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Hormone Issues | <input type="checkbox"/> Lung Conditions |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Arthritis/Joint Problems | <input type="checkbox"/> Blood Clotting Problems | |
| <input type="checkbox"/> Other: _____ | | | |

Current Prescription Medications

Medical Name:	Strength:	Date Started:	How often per day:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Hormones Previously Used

Hormone Name:	Strength:	Date Started:	Date Stopped:	Reason:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Bone Size: Small/Medium/Large *Body Type:* Androgenic/Estrogenic

Family History:

Do you have a family member with any of the following? If so who?

Uterine cancer _____	Ovarian Cancer _____	Breast Cancer _____
Fibercystic Breast _____	Heart Disease _____	Osteoporosis _____

Have you ever used Oral Contraceptives? Yes/No

Any problems? Yes/No if yes describe _____

How many pregnancies have you had: _____

How many children do you have? _____

Have you had a hysterectomy? Yes/No (if yes date _____)

Have you had your ovaries removed? Yes/No

Have you had a tubal ligation? Yes/No (if yes date _____)

When was your last Mammogram? _____

When was your last Pap Smear? _____

Have you ever had abnormal menstrual cycles? (explain) _____

When was your last period? _____ How long did it last? _____

Have you or do you experience PMS? (describe) _____



Hormone Evaluation History

Please check symptoms that apply and their severity

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy/Irregular Menses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin/Hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Disturbances/Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fluid Retention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breakthrough Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Harder To Reach Climax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Sex Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>