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|  | Family First Health CenterFaith, Hope, & HormonesSkinside OutFaylene Dancer, APRN-FNP308-386-4799333 Maple St., Sutherland, NE. 69145 |
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# New Hormone Client Form

Please take a few minutes to fill out this questionnaire that focuses on the important areas of hormone health. We encourage you to answer as honestly as possible. Feel free to add details as you see fit. We ensure you your answers will be kept strictly confidential. Thank you for your participation.

## Name: DOB:

## Symptoms:

## Desires for Improvement/Goals:

## Exam & Hormone History:

### When was your last

 Pap Smear:

 PSA (Prostate Specific Antigen):

 Mammogram:

 Prostate Exam:

Please bring these results with you.

### What previous Hormones have you been on?

### Have you taken or are you currently on Birth Control?

[ ]  Yes | [ ]  No

Types?

# of Years:

### Have you taken or are currently on supplements for hormone help?

[ ]  Yes | [ ]  No

Types?

# of Years:

### Did the above treatments help and to what extent?

[ ]  Yes | [ ]  No

### Do you have a history of blood clots/pulmonary embolus/DVT?

[ ]  Yes | [ ]  No

### Do you have a history of cancer? What type and year of remission?

[ ]  Yes | [ ]  No

Year:

### Do you have a family history of breast or prostate cancer? If yes, please explain.

[ ]  Yes | [ ]  No

### Do you have a family history any other form of cancer? If yes, please explain.

[ ]  Yes | [ ]  No

### Do you have a history of trouble taking hormones or sensitivity to medications?

[ ]  Yes | [ ]  No

### What type of hormone treatment are you most interested in?

[ ]  Pellets [ ]  Creams [ ]  Vaginal only

[ ]  Pills [ ]  Shots (For Men) [ ]  Other

### Do you have any concerns about treatment? If Yes, please explain.

[ ]  Yes | [ ]  No

\*\*Please read through the consent form for hormone treatment. Please bring the copy with you and sign it if you are ready, or bring it in to ask questions about it.