DR. MELANIE BONE
PHYSICIAN AND EDUCATOR

HORMONE CONSULT INTAKE FORM

NAME _____ DATE _____

Are you currently taking hormones?

Yes _____ No _____

If yes, what do you take? Include dose and frequency (if known):

Estrogen _____
Progesterone _____
Testosterone _____
DHEA _____
Pregnenolone _____
Other _____

What symptoms are you trying to treat? Check all that apply:

___Hot flashes/flushes
___Mood Swings
___Night sweats
___Hair loss
___Skin aging
___Fatigue/low energy
___Depression
___Vaginal dryness/painful intercourse
___Weight gain
___Memory/mental “fog”
___Decreased muscle mass
___Low libido/less interest in sex

Do you smoke?

Yes _____ No _____

Have you tried any hormones that have not worked for you?

Yes _____ No _____

If yes, please list them.

_____
_____

Do you have a history of the following? Check all that apply:

___Breast cancer
___Uterine cancer
___Stroke
___Clots in legs or lungs
___Diabetes
___High blood pressure
___Irregular heart beat
___Heart attack

Do you have a regular gynecologist?

Yes _____ No _____

Do you want records sent to him/her?

Yes _____ No _____