Dr, KABONGO CONFIDENTIAL HORMONE EVALUATION

Medical History

Today's Date: _____

Name_____Birthdate:_____Postal Code: _____

Address: _____

City: _____Province:_____Postal Code_____

Phone: _____E-mail Address: _____

Gender: _____ Height: _____Weight:_____

Do you use tobacco? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

Do you use caffeine? ☐ Yes ☐ No

Allergies: Please check all that apply.

☐Penicillin ☐ Morphine ☐ Dye allergies ☐ Pet allergies ☐ Codeine
☐ Aspirin ☐ Nitrate allergy

☐ Seasonal (Pollen) allergies ☐ Sulfa drug

☐ NO known allergies ☐ Other_____

Over-the counter (OTC) issues:

_____

_____

_____

_____

_____

Please check all products that you use occasionally or regularly. Check all that apply.

☐ Pain Reliever

☐ Aspirin

☐ Acetaminophen (example: Tylenol)

☐ Ibuprofen (Example: Motrin IB)

☐ Naproxen (Example: Aleve)

☐ Ketoprofen (Example: Orudix KT)

☐ Cough suppressant (Example: Robitussin)

☐ Antihistamine product (Example: Chlor-Trimeton)

☐ Decongestant product (Example: Sudafed)

☐ Combination product (cough + cold reliever) (Example: Triaminic DM)

☐ Sleep aids (examples: Excedrin PC, Unisom, Sominex, Nytol,)

☐ Antidiarrheal (examples: Imodium, Pepto Bismol, Kaopectate,)

☐ Laxatives, stool softeners (examples: Doxidan, Correctol, etc.)

☐ Antacids (examples: Maalox, Mylanta)

☐ Acid blockers (examples: Tagamet HB, Pepcid C, Zantac 75,)

☐ Other (please list)

NUTRITIONAL/NATURAL SUPPLEMENTS: Please identify and list the products you are using:

☐ Vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)

☐ Minerals (examples: calcium, magnesium, chromium, colloid minerals, and various single minerals)

☐ Herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)

☐ Enzymes (examples: digestive formulas, papaya, bromelain, CoEnzime Q10, etc.)

☐ Nutrition/ protein supplements (examples: shark cartilage, protein powers, amino acids, fish, etc.)

☐ Others (glucosamine, etc.)

Medical Condition / Diseases: Please check all that apply to you.

☐ Heart disease (example: Congestive Heart Failure)

☐ High cholesterol or lipids (example: Hyperlipidemia)

☐ Cancer

☐ Ulcers (stomach, esophagus)

☐ Thyroid disease

☐ Hormonal Related Issues

☐ Lung condition (example: asthma, emphysema, COPD)

☐ Blood Clotting Problems

☐ Diabetes

☐ Arthritis or joint problems

☐ Depression

☐ Epilepsy

☐ Headaches / migraines

☐ Eye Disease (glaucoma, etc.)

☐ Other: Please list below:

_____

_____

_____

_____

Current prescription Medications:

Medication Name, Strength, Date Started, How often per day

_____

_____

_____

_____

_____

_____

List Hormones previously taken:

Hormone, Date Started, Date Stopped, Reason

_____

_____

_____

_____

_____

_____

Bone Size: ☐ Small ☐ Medium ☐ Large

Body Type: ☐ Androgenic ☐ Estrogenic

Have you ever used oral contraceptives? ☐ No ☐ Yes

Any problems? ☐ No ☐ Yes

If Yes, describe any problem (s)

_____

_____

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? ☐ No ☐ Yes

Have you had a hysterectomy? ☐ No ☐ Yes (Date of Surgery):_____

Ovaries removed? ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes (Date) _____

Do you have a family history of any of the following?

☐ Urine Cancer Family member(s) _____

☐ Ovarian Family member(s) _____

☐ Fibrocystic breast Family member (s) _____

☐ Breast Cancer Family member(s) _____

☐ Heart Disease Family member(s) _____

☐ Osteoporosis Family member(s) _____

Additional Notes:

_____

_____

Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography ☐ No ☐ Yes (Date): _____

PAP Smear ☐ Yes ☐ Yes (Date): _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? ☐ No ☐ Yes Date: _____

If YES, please explain (such as age when this occurred, symptoms….):

_____

_____

_____

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ☐ No ☐ Yes

If YES, explain symptoms:

_____
_____
_____

Do you consider Bio-Identical Hormone Replacement Therapy? ☐ No ☐ Yes

Please write down any questions:

_____
_____
_____
_____
_____
_____
_____