



CONFIDENTIAL HORMONE EVALUATION Medical History

Today's Date _____

Name: _____ Birth date: _____ Age: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: () _____ Email: _____

Gender: Male Female Height: _____ Weight: _____

How often and how much?

Do you use tobacco? Yes No _____

Do you use alcohol? Yes No _____

Do you use caffeine? Yes No _____

Doctor's Name: **Address:** **Phone:**

Allergies: Please check all that apply.

- | | | | |
|-------------------------------------|---|---|---|
| <input type="checkbox"/> penicillin | <input type="checkbox"/> morphine | <input type="checkbox"/> dye allergies | <input type="checkbox"/> pet allergies |
| <input type="checkbox"/> codeine | <input type="checkbox"/> aspirin | <input type="checkbox"/> nitrate allergies | <input type="checkbox"/> seasonal allergies |
| <input type="checkbox"/> sulfa drug | <input type="checkbox"/> food allergies | <input type="checkbox"/> No known allergies | other _____ |

Please describe the allergic reaction you experienced and when it occurred:

Over-the-counter (OTC) issues

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

- | | |
|---|--|
| <input type="checkbox"/> pain reliever | <input type="checkbox"/> combination product (cough+cold reliever) |
| <input type="checkbox"/> aspirins | <input type="checkbox"/> sleep aids (example: Unisom [®]) |
| <input type="checkbox"/> acetaminophen (example: Tylenol [®]) | <input type="checkbox"/> anti- diarrheas (example: Imodium [®]) |
| <input type="checkbox"/> ibuprofen (example: Motrin [®]) | <input type="checkbox"/> laxatives (example: Doxidan [®]) |
| <input type="checkbox"/> naproxen (example: Aleve [®]) | <input type="checkbox"/> diet aids (example: Dexatrim [®]) |
| <input type="checkbox"/> ketoprofen (example: Orudis [®]) | <input type="checkbox"/> antacids (example: Maalox [®]) |
| <input type="checkbox"/> cough suppressant (example: Robitussin [®]) | <input type="checkbox"/> acid blockers (example: Tagamet [®]) |
| <input type="checkbox"/> antihistamine (example: Chlor-Trimeton [®]) | <input type="checkbox"/> Other please list |
| <input type="checkbox"/> decongestant (example: Sudafed [®]) | _____ |