HEALTHQUEST
Longevity Center

DR. DANA Q. PLETCHER DR. JEFF J. WATKIN

Hormone Evaluation Consultation

Patient Name_____
Appointment Time_____

Complete this form by printing legibly in ink. This form must be completed in its entirety in order for your evaluation to take place. If categories are not applicable to you in "N/A" or "None."

Consulting Doctor's Name_____

Patient_____
Address/City/State/Zip_____
Phone _____

Sex: M F Age:_____ DOB: _____ Weight:_____ Height:_____

If you are a woman of child bearing age are you pregnant? Yes No
If not, do you intend to become pregnant in coming 2 years? Yes No

Patient

Please list the main hormonal health problems, symptoms and complaints that this consultation will address (in narrative form)._____

_____

_____

Consulting Doctor

Please list the clinical findings/symptoms of the patient._____

_____

_____

Signature of Consulting Doctor_____ Date: _____

700 Florsheim Drive
Suite 12
Libertyville, Illinois 60048
USA

Phone: 847-367-7131
Fax: 847-367-7482
Email: HealthEQuest@hotmail.com
Website: www.healthquestradio.com

PATIENT NAME:_____

General Health History

Please mark (X) if you have a personal or family history. Specify the nature and duration of the problem when personal history applies.

Family	Personal	Health Problem	Duration (Personal)
		Blood Pressure	
		Heart Disease	
		Diabetes	
		Stroke	
		Neurological Disorder	
		Cancer	
		Skin Problems	
		Gastrointestinal Problems	
		Liver	
		Asthma	
		Arthritis	
		Osteoporosis	
		Mental Disorder	

Health Data

Please list ***most recent result/date/place*** of the following tests.

1. Last physical exam_____
2. Bone density test (DEXA)_____
3. NTX or DPD (osteoporosis urine test)_____
4. Colonoscopy/Sigmoidoscopy_____
5. Traveling in a third-world country (date & place)_____
6. HIV Status_____
7. Chest X-Ray_____
8. Serum Cholesterol Count_____
9. EKG (heart exam)_____
10. Tuberculosis (TB) skin test_____
11. Prostate or testicular exam_____
12. Mammogram_____
13. Breast exam_____
14. Hepatitis screen_____

PATIENT NAME:_____

Mark (X) by all applicable statements. I have had, or currently have:

_____ Uterine Fibroids
_____ Breast Cancer
_____ Premenstrual Syndrome (water Retention, breast tenderness)
_____ Endometriosis
_____ Prostate Enlargement
_____ Prostate Cancer
_____ Ovarian Cysts

List other hormonal problems:_____

_____
_____
_____
_____
_____
_____

PATIENT NAME:_____

Menstrual & Reproductive History

Menses

1. Age at which your period began:_____
   a. Dates your last six periods began:_____, _____, _____, _____, _____, _____
   b. If menopausal, month and year of last menses _____
2. Regular Periods? ( ) No ( ) Sometimes ( ) Yes
   a. Periods every ___ days (length of entire cycle)
3. Flow: ( ) Heavy ( ) Medium ( ) Light
   a. Duration: ___ days (length of flow days)
4. Spotting? ( ) No ( ) Yes Instead of period? ( ) No ( ) Yes
5. Bloating? ( ) No ( ) Yes Weight Gain? ( ) No ( ) Yes
   How Much?___ lbs.
6. Cramps? ( ) No ( ) Yes Duration: ___ days
   Intensity: ( ) Mild ( ) Moderate ( ) Severe
7. PMS? ( ) No ( ) Yes Describe:_____
8. Number of days you experience PMS: _____

Pelvic Exam

9. Date of last pelvic exam:_____ Performed By: _____ Reason: _____
10. Date of last PAP smear:_____ Results: _____
11. Previous Abnormal PAP? ( ) No ( ) Yes Date:_____ Results: _____
    Therapy: _____
12. Recurring vaginal yeast infections? ( ) No ( ) Yes Onset: _____
    Frequency: _____
13. Did you mother take the drug DES during her pregnancy? ( ) No ( ) Yes

Breast Exam

14. Breast Pain or Lumps? ( ) No ( ) Yes Breast Discharge? ( ) No ( ) Yes
15. Date of last mammogram:_____ Results:_____
16. Do you examine your own breasts each month? ( ) No ( ) Yes
    If not monthly, how often?_____

Hormones

17. Menopausal? ( ) No ( ) Yes Perimenopausal (beginning symptoms)? ( ) No ( ) Yes
18. Hot Flashes: ( ) No ( ) Yes Onset:_____ Rx: _____
    Frequency: _____ times per day/week for _____ minutes.
    Intensity: ( ) Mild ( ) Moderate ( ) Severe
19. Painful intercourse? ( ) No ( ) Yes Vaginal dryness? ( ) No ( ) Yes

Pregnancy

20. Currently pregnant? ( ) No ( ) Yes Planning? ( ) No ( ) Yes When? _____
21. Prior pregnancies: #_____ Births: #_____ C-Sections: #_____
    Miscarriages: #_____ Abortions: #_____
22. Complications: ( ) No ( ) Yes Describe:_____
23. Sexually active? ( ) No ( ) Yes Type of birth control you use now:_____

PATIENT NAME:_____

Please print name and give dose of all current prescription and hormone medications you are using. Do not list vitamins or minerals.

Medication/Treatment **Dose/Frequency**

_____

_____

_____

_____

_____

Please list any known allergies to medications: _____

_____

_____

_____

Please list any surgical procedures and dates (exclude dental): _____

_____

_____

_____

Do you currently have: ( ) Uterus

( ) No Uterus Date Removed:_____ Reason:_____

( ) Two Ovaries

( ) One Ovary Date Removed:_____ Reason:_____

( ) No Ovaries Date Removed:_____ Reason:_____

Endocrinology History

Duration	**Diagnosis**	**Current Medication & Dose**
_____	Pituitary:_____	_____
_____	Thyroid:_____	_____
_____	Parathyroid:_____	_____
_____	Adrenal:_____	_____
_____	Testicles:_____	_____
_____	Ovary:_____	_____

PATIENT NAME:_____

Any other major medical illnesses, please list and describe.

_____

_____

_____

_____

_____

General Endrocrine Symptoms Checklist

Please rate the severity of the symptom(s) or condition when it is present by using the Wellness Gauge Scale (1 to 10): **1= symptom is severe** **10=symptom is not severe**

	Fatigue (excessive)		Joint inflammations (Arthritis)
	Nervousness/Anxiety		Low blood pressure
	Depression		Low body temperature
	Irritability (inappropriate anger)		Feel chilled easily
	Apprehensiveness		Cold hands or feet
	Weakness		Loss of appetite
	Lightheadedness/faintness		Indigestion
	Hypoglycemia		Gas, bloating
	Insomnia		Diarrhea or constipation
	Headaches		Food allergies
	Palpitation/rapid heart beat		Airborne allergies
	Difficulty thinking/concentrating		Inactive lifestyle (little exercise)
	Muscle aches/pains (fibromyalgia)		Very active (high exercise level)

PATIENT NAME:_____

Female Hormone Imbalance Rating

Please rate the severity of the symptom(s) or condition when it is present by using the Wellness Gauge Scale (1 to 10): **1= symptom is severe** **10=symptom is not severe**

	Abdominal pain		Irritable or anxious
	Allergies		Meat-eater (rate frequency
	Anger easily		Menstrual cramps
	Back pain		Menstrual migraines
	Bloating		Mood swings
	Chronic stress		Night sweats
	Depression		Ovarian cyst(s)
	Disinterest in sex/low sex drive		Pain with intercourse
	Endometriosis		PMS
	Fatigue		Rheumatoid arthritis
	Fibrocystic breast disease		Skin problems
	Fibroids		Spotting between menses
	Fluid retention		Subfertility
	Food cravings/binge eating		Tender breasts
	Heavy menstrual bleeding		Vaginal dryness
	Hot flashes		Yeast problems
	Insomnia		
	Irregular menstrual cycle		**TOTAL SCORE**

Past or Present Condition: (1=yes 10=no)

	Birth control pills		Loss of height/Bone loss
	Cancer: (list type)_____		Miscarriage
	DES daughter		Ovarian cancer
	Family history of osteoporosis		Premature menopause (<45 yrs old)
	Hysterectomy		
	Infertility (never able to conceive)		**TOTAL SCORE**

GRAND TOTAL:_____

PATIENT NAME:_____

Answer each question by circling yes or no. Have you ever had or currently have:

Yes	**No**	Breast Cancer or Prostate Cancer
Yes	**No**	Uterine Cancer or Cervical Cancer
Yes	**No**	Currently pregnant
Yes	**No**	Currently breast feeding
Yes	**No**	Heart/liver/kidney disease (circle appropriate)
Yes	**No**	Thrombophlebitis (deep vein pain/clotting issue)
Yes	**No**	Thromboembolic disorder (blood clotting problem)
Yes	**No**	Estrogen-related cancer
Yes	**No**	Undiagnosed abnormal genital bleeding
Yes	**No**	Family history of breast cancer
Yes	**No**	Family history of uterine or cervical cancer
Yes	**No**	Breast cysts, breast nodules, fibrocystic breasts, abnormal mammogram
Yes	**No**	Severe liver disease
Yes	**No**	History of severe hypersensitivity to drugs
Yes	**No**	Genital cancer (Vaginal or Testicular)
Yes	**No**	Use blood thinning medications
Yes	**No**	Severe reaction to estrogen or progesterone

Please describe in detail each YES answers given above.