Initial Hormone Consultation Visit

Date of Visit: ______________________
Name: ________________________________ Date of Birth: ______________
Age: ___________
I was referred by: ____________________________
for: ____
My Problems: ____
Questions for Dr. Cobb: ____
____
____

I am: ( ) Premenopausal ( ) Perimenopausal ( ) Menopausal
Birth Control currently: ____________________________(menopause is a choice)
Last Period: ______________
Sexual history: ( ) I am sexually active ( ) I am interested in becoming sexually active ( ) I am not interested in sexual activity
Preventive tests I have had within last 12 months:
( ) Pap smear ( ) Mammogram ( )Bone Density ( )Heart Tests
Please list any abnormalities of the tests listed above:
____
____

I have been told I have:
( )PMS ( )Thyroid disease ( )Diabetes ( )Insulin resistance
( )Hormone imbalance ( )Metabolic syndrome
( )Polycystic Ovaries ( )Adrenal disease ( )Depression ( )Anxiety
Other: ____

Hormones I have tried in the past:	Problems w/ these hormones:
______________________________	______________________________
______________________________	______________________________

Hormones I am on now:
____

Other Current medications:
____
____
____

Surgery I have had:
( ) Hysterectomy ( )Removal of both ovaries ( )D&C
( )Breast surgery for cancer ( )Thyroid surgery
Goal for this visit:
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____

PATIENT QUESTIONNAIRE TO BEGIN HORMONE THERAPY

Name: ____ Date: ____________

Age: __________ Date of Last Period: ______________

Please circle the symptoms that are true for you:

1. I have hot flashes and night sweats that impair my sleep.
2. I have developed dry eyes.
3. I have migraines that have gotten worse since my 30's.
4. I have PMS.
5. I am depressed.
6. I am anxious.
7. I am more irritable than I was a few years ago.
8. I do not enjoy life anymore.
9. I have gained weight since my symptoms started.
10. My strength has decreased as well as my exercise tolerance.
11. I have developed cellulite and poor skin tone.
12. I have a new onset of wrinkles and drooping skin.
13. I have no energy.
14. My sex drive is gone.
15. My husband/partner and I are not getting along.
16. I feel hopeless.
17. I cannot think clearly anymore.
18. My memory for names is gone.
19. I don't sleep through the night and have no energy during the day.

Past Medical History (please circle):

Breast Cancer Uterine Cancer Ovarian Cancer

Myocardial Infarction Life Threatening Blood Clots

Other ____

Allergies to Drugs: ____

Medications: ____

____

Family History (please circle):

Breast Cancer Uterine Cancer Ovarian Cancer

Myocardial Infarction Life Threatening Blood Clots

Other ____

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Patient Signature

Hormone Diary *Name:*___________________________

Symptoms: *rate 1-10*	**Before Treatment**	/ /	/ /	/ /	/ /	/ /	/ /
Fatigue							
Insomnia							
Lack of Sexual Desire							
Poor Memory							
Weight Gain							
Depression							
Anxiety							
Swelling							
Muscle weakness							
Wrinkles, Skin sagging							
Migraine Headaches							

Hair Loss							
Dry skin							
Low Voice							
Facial Hair							
Nausea							
Enlarged Clitoris							