Dr. Gail Jackson

Hormone Status Evaluation

Date: _____ Patient Name: _____ DOB: _____
Weight:_____Height:_____

Tell Us About Yourself

Do you have Fibroid Tumors? Yes_____No_____
Have you had any surgery or procedures to treat the Fibroids?_____
If yes, which one?_____
Have you had a Hysterectomy? Yes_____No_____
Were your ovaries removed? Yes_____No_____
Have you taken other methods of Hormone Replacement Therapy? Yes_____ No_____
What did you take? _____
What other medications are you taking now? _____
_____

What Vitamin/Nutrition Supplements are you taking? _____
_____

Would you like to lose weight? _____
If yes, How many pounds? _____
Have you or a family member ever had any history of Cancer?

	You	Family Member (Please State Relationship)
1.	Uterine Cancer: _____	_____
2.	Ovarian Cancer: _____	_____
3.	Breast Cancer: _____	_____

Have you or a family member ever had history of the following and who?

	You	Family Member (Please State Relationship)
1.	Osteoporosis: _____	_____
2.	Heart Disease: _____	_____
3.	High Blood Pressure:_____	_____
4.	Diabetes: _____	_____
5.	Blood Clots: _____	_____

Please check the symptoms you are experiencing:

Symptoms:	Yes	No	Symptoms:	Yes	No
Difficult Sleeping			Fatigue		
Short Term Memory Loss			Weight Gain		
Gloomy or Sad			Decreased muscle tone		
Irritability			Loss of body contour		
Anxiety			Harder to reach climax		
Moodiness			Vaginal Dryness		
Hot Flashes			Decreased sex drive		
Night Sweats			Loss of urine with exercise		
Dry Skin			Loss of urine when you cough/sneeze		
Easily Angered			The gotta goes/urgency		

What results do you desire from hormone balancing? _____
Consultation completed by:_____ **Date**:_____