TURNER
DERMATOLOGY

Hormone Therapy Health Screening

Name: _____ **Date of Birth**:_____ **Age**:_____

Height: _____ **Weight:** _____

Medical History: Please circle all that apply

Breast Cancer	Abnormal Mammogram	Ovarian, uterine, or cervical cancer
Endometriosis or Fibroids	Blood clots (DVT or PE) or clotting disorder	
Heart Disease	Heart attack	Stroke/TIA
High blood pressure	Diabetes or prediabetes	Liver or gallbladder disease
Migraine headaches	Depression or Anxiety	Thyroid disorder
Kidney Disease	Seizures or other neurological disorders	
Autoimmune disorders (ie: Lupus, Rheumatoid arthritis)		Unexplained vaginal bleeding
Irritable bowl disease	Porphyria Cutanea Tarda	

Other chronic conditions: _____

If you circled any of the above, please explain:

_____

_____

_____

Past Surgical History:

History of Hysterectomy, oophorectomy, breast surgery: _____

_____

Recent fracture or broken bones: _____

List all surgeries and approximate dates: _____

_____

Family History (first-degree relative: parents, sibilings): please circle

Breast Cancer Ovarian or Uterine Cancer Blood Clots or Stroke

Diabetes Heart Disease before age 60

GYN/Reproductive History:

Age of first period: _____ Date of last menstrual cycle: _____

If still getting periods, are they regular? _____

Number of pregnancies: _____ Number of live births: _____

Complications during pregnancy (gestational diabetes, pre-eclampsia, preterm delivery: _____

_____

History of PCOS? _____ Currently pregnant or breastfeeding? _____

Has your uterus or ovaries been removed? _____

Last pap was _____ Result _____

Last mammogram _____ Result _____

Last bone density _____ Result _____

Current Medications and Supplements:

List all medications as well as OTC drugs, vitamins, and supplements:

_____
_____
_____
_____

Do you take St. John's Wort? _____

Are you currently using any hormones: Birth control, thyroid, testosterone, estrogen, progesterone? _____

Allergies:

Please list all drug allergies: _____

_____

_____

Please list all food allergies: _____

_____

_____

Lifestyle:

Do you currently smoke or vape? _____ If "yes", how many per day? _____

Are you a former smoker? _____ If "yes", how long did you smoke? _____

When did you quit? _____

Do you drink alcohol? _____ How much per week? _____

Do you use recreational drugs? _____

What are your exercise habits? _____

How many hours of sleep do you get on average? _____

Diet pattern: _____

Recent Symptoms: Please circle all that apply to you

Hot flashes/night sweats Low Libido Fatigue

Vaginal dryness/pain with intercourse Mood swings/Depression/Anxiety

Hair loss/ excessive hair growth Breast tenderness Headaches/migraines

Fluid retention or bloating Other Symptoms: _____