

Dr. Shel Wellness & Medical Spa BHRT Consultation

Date: _____ Referred By: _____
Name: _____ Email: _____
Address: _____
City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____
Age: _____ D.O.B: _____ Social Security #: _____
Marital Status: M W D Sp S Occupation: _____ DL#: _____
Date of Last Menstrual Period: _____
Reason for Visit: _____

Please check all applicable and explain:

- | | | |
|----------------------------|-------------------------|----------------------------|
| ↑ Excessive Weight | ↑ Hepatitis | ↑ Mental Health/Depression |
| ↑ Chronic Fatigue Syndrome | ↑ HIV Positive | ↑ Mitral Valve Prolapse |
| ↑ Colitis | ↑ Hypertension | ↑ Multiple Sclerosis |
| ↑ Diabetes | ↑ Hyperthyroidism | ↑ Chronic Yeast Infection |
| ↑ Elevated Cholesterol | ↑ Irrit. Bowel Syndrome | ↑ Seizures |
| ↑ Elevated Triglycerides | ↑ Kidney Disease | ↑ Sleep Disorders |
| ↑ Heart Disease | ↑ Stroke | ↑ Skin Complaints |

Health Maintenance: (Date last done)

Bone Density: _____ MMG _____ Pap _____
Lipid Profile: _____ Flex Sigmoidoscopy _____
Td: _____ Influenza _____
Influenza: _____ Pneumovax _____
Medical Problems: (Explained from above) _____

Current Medications/Supplements: _____

BCP _____ Hormones _____

Do you have any drug allergies? ↑ No ↑ Yes Give reaction _____

Do you exercise? ↑ No ↑ Yes What kind? _____ How Often _____

Do you smoke? ↑ No ↑ Yes How much? _____ How Long? _____

Do you use alcohol? ↑ No ↑ Yes How much? _____ How Long? _____

Have you had a major illness/hospitalization/surgery? ↑ No ↑ Yes

Explain: _____

Is there a family history of: (Please check)

- | | | | |
|-----------------------|------------------|---------------|-----------------|
| ↑ Colon Cancer | ↑ Ovarian Cancer | ↑ Diabetes | ↑ Breast Cancer |
| ↑ High Blood Pressure | ↑ Heart Disease | ↑ Other _____ | |

Are you interested in our other services:

- | | | |
|-----------------------|-------------------------|-----------------------|
| ↑ Nutritional testing | ↑ Laser Rejuvenation | ↑ Cellulite Treatment |
| ↑ Skin Care | ↑ Weight Management | ↑ Mineral Makeup |
| ↑ Laser Hair Removal | ↑ Laser Skin Tightening | ↑ Lymphatic Massage |

Drug Allergies

To what drugs are you allergic?

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Family History

	Medical Problem(s)
Father- alive or deceased? Age _____	_____
Mother- alive or deceased? Age _____	_____
Brothers/sisters: _____	Medical Problem(s) _____
_____ Age _____	_____
_____ Age _____	_____
_____ Age _____	_____

REVIEW OF SYMPTOMS

Heart

- Y N** Do you ever feel your heart skip a beat? How often? _____
For how many years? _____
- Y N** Do you have chest pain? How often? _____
For how many years? _____
Is the pain sharp / stabbing / dull / aching? Does it radiate to your neck, back, or shoulders?
- Y N** How long does the pain last? _____
- Y N** Do you feel like you are going to pass out?

Gastrointestinal System

- Y N** Do you have abdominal cramping, bloating, excessive belching or intestinal gas?
How often? _____ x/week _____ How long? _____

Urinary Tract

- Y N** Have you ever had bladder infections / kidney infections?
How many x/year? _____ For how many years? _____
- Y N** Have you ever had kidney stones? How many times? _____
Year of last episode _____
- Y N** Do you have burning upon urination?
- Y N** Do you have increased frequency of urination?

Yeast/Skin Fungus

- Y N** Have you ever had a vaginal yeast infection? How many times? _____
How many x/year? _____ How many years? _____
Between what years? _____ and _____

Skin

- Y N** Do you have any unexplained skin rashes or itchy skin?

How long? _____ months _____ years
Do you know the cause of your rashes/itchy skin? _____

Thyroid

Y N Have you been diagnosed with a thyroid disorder? Year diagnosed _____
Y N Were you diagnosed with hyperthyroidism
Y N Were you diagnosed with hypothyroidism
Y N Did you ever take thyroid medication? What year did you quit? _____
Name of medicine _____ Dose _____ mg

Malaise/Fatigue

Y N Do you feel you should have more energy?
What is your average energy level on a scale of 0 to 10 with 10 meaning brimming
with energy
and 1 or 2 meaning the inability to get out of bed?
ENERGY LEVEL 0-10 ____ /10 For how many years? _____

Hair Condition

Y N Do you have coarse or fine hair? For how many
years? _____
Y N Have you ever had significant hair loss?
How long? _____ months _____ years

Weight

Y N Have you had significant weight gain? How many
pounds? _____
Since what year? _____
Y N Do you have difficulty losing weight? How long? _____

Mood

Y N Do you ever feel discouraged, blue or depressed more than 10% of the time?
What percent of the time? _____ % For how many years? _____
Y N Have you ever taken anti-depressants?
Which one(s)? _____
Between what _____ y.o. and _____ y.o.
ages? _____

Skin

Y N Do you have dry skin? For how many years? _____

Sleep

Y N Do you have insomnia or restless sleep? How many
years? _____
How many
Y N Do feel tired after a full night's sleep? years? _____
Y N Do you have afternoon fatigue?
How many hours of sleep do you _____ hours/night?
require? _____

MENSTRUAL HISTORY - PREMENOPAUSAL QUESTIONS

Pregnancy

Date of last normal menstrual period? _____ / _____ / _____

At what age did you enter puberty? _____ y.o.

How many pregnancies? _____ live births? _____ miscarriages? _____

Date of last child's birth _____ Your age then? _____

Y N Did you have difficulty becoming pregnant?

Y N Did you ever receive infertility treatment? _____ What kind? _____

Birth Control

Y N Have you had bilateral tubal ligation? If yes, _____ / _____ (mo/yr) when? _____

Y N Are you currently using an IUD?

Y N Have you ever taken Depo- Provera?

Y N Did you ever take birth control pills?
If yes, for how long? _____ mos _____ yrs
Date you discontinued BCP _____ / _____

Y N Are you currently taking any female hormones (progesterone or estrogen)?
If yes, which ones? _____
For how long? _____

Pap Smear

Y N Have you had an abnormal pap smear?
If yes, when? _____ / _____ (mo/yr)

Y N Was your most recent pap smear normal?
Date: _____ / _____ (mo/yr)

Menstrual Periods

Y N Do your menstrual periods occur at the same time each month?
If no, what is the shortest number of days between periods? _____
What is the longest number of days between periods? _____
How long have your menstrual cycles been _____ months _____ years irregular?

Y N Were your menstrual cycles ever regular? _____
How many days do your periods last? _____ days

Y N Are your periods heavier or lighter than in the past?
If yes, when did they change? _____ (mo/yr)

Y N Do you have intermenstrual bleeding that occurs between your normal periods?
If yes, for how long has this _____ months _____ years occurred? _____

Premenstrual Syndrome

- Y N** Do you have breast tenderness prior to your period?
If yes, how many days prior to your period does it begin? _____ days
For how long has this _____ months _____ years
occurred?
- Y N** Do you have mood swings to your period?
If yes, how many days prior to your period does it _____ days
begin? _____
For how long has this _____ months _____ years
occurred?
- Y N** Do you have fluid retention prior to your period?
If yes, how many days prior to your period does it _____ days
begin? _____
For how long has this _____ months _____ years
occurred?
- Y N** Do you have weight gain prior to your period?
Approximately how many pounds do you gain prior to your _____ lbs.
periods? _____
For how long has this _____ months _____ years
occurred?
- Y N** Do you crave sweets or bread products prior to your periods?
Y N Do you develop headaches (not migraine) prior to your periods?
If yes, how many days prior to your period do they begin? _____ days
For how long has this _____ months _____ years
occurred?
- Y N** Do you have menstrual cramps? If yes, for how many days? _____
- Y N** Do you experience hot flashes? For how long? _____ months _____ years
- Y N** Do you have night sweats? For how many years? _____
- Y N** Have any of the above symptoms ever caused you to miss work or school, or cause you to be unable to do daily functions?

Estrogen Dominance

- Y N** Do you have fibrocystic breast disease? how long? _____ months _____ years
- Y N** Have you ever had endometriosis? how long? _____ months _____ years

Y N Do you have uterine fibroids? how long? _____ months _____ years

Y N Have you had ovarian cysts? How many times? _____
Which side? ___ left _____ right

Y N Have you developed dark hair on your face?
How long ago did it
begin? _____ months _____ years

Y N Have you developed dark hair on your breasts?

How long ago did it
begin? _____ months _____ years

Y N Have you had a decrease in sexual desire?
For how long? ___ months _____ years

Y N Have you ever had pain or discomfort during or after intercourse?

Y N Due to vaginal dryness?
For how long? _____ months _____ years

Bone Density

Y N Have you ever been diagnosed with osteoporosis?

Recurrent Medications

Y N Do you currently take prescription medication? Please list the strength,
times/day taken, and number of years taken:

- | | |
|----------|----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |

Dr. Shel Wellness & Medical Spa

Hormone Checklist

Check applicable symptoms of each category:

Estrogen Deficiency

- | | |
|--|--|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Foggy Thinking | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Dry Skin/Hair |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Tearful | |

Estrogen Excess

- | | |
|--|--|
| <input type="checkbox"/> Mood Swings (PMS) | <input type="checkbox"/> Fibrocystic Breasts |
| <input type="checkbox"/> Tender Breasts | <input type="checkbox"/> Uterine Fibroids |
| <input type="checkbox"/> Water Retention | <input type="checkbox"/> Weight Gain (Hips) |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Bleeding Changes |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> Cold Body Temperature | <input type="checkbox"/> Weight Gain waist |

PROGESTERONE DEFICIENCY

- | | |
|--|--|
| <input type="checkbox"/> Candida Infections | <input type="checkbox"/> Fluid Retention |
| <input type="checkbox"/> Fibrocystic Breasts | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stressed easily |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Water retention |

PROGESTERONE DEFICIENCY

- | | |
|---|--|
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Break-thru bleeding |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Heavy Periods | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Irregular cycles |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Hypothyroidism |

Androgen Deficiency

- | | |
|--|--|
| <input type="checkbox"/> Low libido | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Vaginal Dryness | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Thinning Pubic Hair |
| <input type="checkbox"/> Aches/Pains/Arthritis | <input type="checkbox"/> Decreased Muscle Mass |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Bone Loss |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Thinning Skin |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Fibromyalgia |

Androgen Excess

- | | |
|---|--|
| <input type="checkbox"/> Excessive Facial Hair | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Excessive Body Hair | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Increased Acne | <input type="checkbox"/> Hair Loss scalp |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Nervous/Irritable |
| <input type="checkbox"/> Elevated Triglycerides | |

Cortisol Deficiency

- | | |
|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold Body Temp. |
| <input type="checkbox"/> Sugar Cravings | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Chemical Sensitivity | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Aches / Pains |

Cortisol Excess

- | | |
|---|--|
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Heart Palpitation |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Weight Gain/Loss | <input type="checkbox"/> Cold Body Temp |
| <input type="checkbox"/> Muscle Mass Loss | <input type="checkbox"/> Sugar Cravings |
| <input type="checkbox"/> Thinning Skin | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Increased Facial Hair |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Increased Body Hair |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Nervous |

THYROID DEFICIENCY

- | | |
|---|---|
| <input type="checkbox"/> Tired or Exhausted | <input type="checkbox"/> Difficult to Concentrate |
| <input type="checkbox"/> Sad or Depressed | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Cold Body Temp. | <input type="checkbox"/> Swelling/Puffy eye/face |
| <input type="checkbox"/> Cold Hands & Feet | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Slow Pulse Rate |
| <input type="checkbox"/> Can't Lose Weight | <input type="checkbox"/> Decreased Sweating |
| <input type="checkbox"/> Memory Lapse | <input type="checkbox"/> Hair Dry/ Brittle |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Hair Loss |

THYROID DEFICIENCY

- | | |
|--|---|
| <input type="checkbox"/> Nails breaking/ Brittle | <input type="checkbox"/> Infertility Problems |
| <input type="checkbox"/> Aches / Pains | <input type="checkbox"/> Slowed Reflexes |
| <input type="checkbox"/> Low Libido | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Heart Palpitation | <input type="checkbox"/> Thick Tongue |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Slow Ankle Reflex |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Decreased Muscle Mass | |
| <input type="checkbox"/> Thinning Skin | |