

THE LIME IN THE COCONUT CONFIDENTIAL HORMONE EVALUATION

MEDICAL HISTORY

Today's Date: _____

Name: _____ Birthdate: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-Mail Address: _____

Cell Phone: _____ Work Phone: _____

Preferred Phone Contact: Home Cell Work

Gender: Male Female Height: _____ Weight: _____

How often and how much?

Do you use tobacco? Yes No _____

Do you use alcohol? Yes No _____

Do you use caffeine? Yes No _____

How much water do you drink in 1 day? _____

Doctor's Name: _____ Address: _____ Phone: _____

Allergies: Please check all that apply.

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ seasonal (pollen)
___ sulfa drug ___ food allergies Other: _____ ___ no known allergies

Please describe the allergic reaction you experienced and when it occurred?

Over-the-counter (OTC) issues:

Please check all products that you use occasionally or regularly. Check all that apply.

- Pain Reliever
- Aspirin
- Acetaminophen (example: Tylenol®)
- Ibuprofen (example: Motrin IB®)
- Naproxen (example: Aleve®)
- Ketoprofen (example: Orudis KT®)
- Cough suppressant (example: Robitussin DM®)
- Antihistamine product (example: Chlor-Trimeton®)
- Decongestant product (example: Sudafed®)
- Combination product (cough+cold reliever)(example: Triaminic DM®)
- Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
- Antidiarrheals (examples:Imodium®, Pepto Bismol®, Kaopectate®)
- Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
- Diet aids/weight loss products (example: Dexatril®)
- Antacids (examples: Maalox®, Mylanta®)
- Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
- Other (please list)

Nutritional/Natural Supplements: Please identify and list the products you are using:

- vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
- minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)
- others (glucosamine, etc.)

Medical Conditions/Diseases: Please check all that apply to you.

- Heart disease (example: Congestive Heart Failure)
- High cholesterol or lipids (examples: Hyperlipidemia)
- High blood pressure (example: Hypertension)
- Cancer
- Ulcers (stomach, esophagus)
- Thyroid disease
- Hormonal Related Issues
- Lung condition (example: asthma, emphysema, COPD)
- Blood Clotting Problems
- Diabetes
- Arthritis or joint problems
- Depression
- Epilepsy
- Headaches/migraines
- Eye Disease (glaucoma, etc.)
- Other: Please list: _____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day.
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List Hormones previously taken.

Date Started	Date Stopped	Reason
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Have you ever used oral contraceptives? No Yes

Any problems? No Yes

If YES, describe any problem(s).

PATIENT NAME: _____

How many pregnancies have you had? _____ How many children? _____

Any interrupted pregnancies? No Yes

Have you had a hysterectomy? No Yes (Date of Surgery) _____

Ovaries removed? No Yes

Have you had a tubal ligation? No Yes (Date) _____

Do you have a family history of any of the following?

Uterine Cancer _____ Family member(s) _____
Ovarian Cancer _____ Family member(s) _____
Fibrocystic breast _____ Family member(s) _____
Breast Cancer _____ Family member(s) _____
Heart Disease _____ Family member(s) _____
Osteoporosis _____ Family member(s) _____

Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography No Yes Date: _____
PAP Smear No Yes Date: _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? No Yes Date: _____

If YES, please explain (such as age when this occurred, symptoms....):

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? No Yes

If YES, explain symptoms:

PATIENT NAME: _____

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Heavy/Irregular Menses	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Breast Tenderness	_____	_____	_____	_____
Sleep Disturbances/Insomnia	_____	_____	_____	_____
Cramps	_____	_____	_____	_____
Fluid Retention	_____	_____	_____	_____
Breakthrough Bleeding	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Bladder Symptoms	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Harder to Reach Climax	_____	_____	_____	_____
Decreased Sex Drive	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____

Patient Name: _____ **Date:** _____

Return to The Lime in the Coconut: Fax (573)964-5270

Mail: PO Box 2145 Lake Ozark, MO 65049

THE LIME IN THE COCONUT Insurance Information

Name on Card: _____

Card Holder's Birthdate: _____

Relation to card holder: _____

Type of Insurance: _____

Card or ID #: _____ Group #: _____

Bin #: _____

Please provide a copy of the front and back of your insurance card.