Holistic Hormone Harmony Clinic
holisitc-hormone-clinic.com
Phone: 02 6021 3555
Email: admin@holistic-hormone-clinic.com

Medical History and Medications

Please provide as much detail as possible.

Current symptoms and concerns (top 3)

1. _____
2. _____
3. _____

Past medical history (tick all that apply)

[ ] Thyroid condition [ ] Diabetes [ ] High blood pressure
[ ] High cholesterol [ ] Heart disease [ ] Blood clots
[ ] Osteoporosis [ ] Anxiety or depression
[ ] Autoimmune condition [ ] Cancer (type): _____
[ ] Sleep apnoea [ ] Migraine [ ] Endometriosis / PCOS
Other: _____

Surgical history (procedure and year)

_____
_____

Allergies (including reactions)

_____
_____

Holistic Hormone Harmony Clinic
holisticharmonyhormones.com.au
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Email: hello@holisticharmonyhormones.com.au

Medical History and Medications

Continued

Current medicines (name, dose, frequency)

Supplements / vitamins / herbal products

Previous hormone therapy or contraception

Family history (major conditions)

Lifestyle snapshot

Smoking: [ ] Never [ ] Former [ ] Current

Alcohol: [ ] None [ ] Occasional [ ] Weekly [ ] Daily

Exercise per week: ____ sessions Average sleep: ____ hours

Women (if applicable)

Last menstrual period: ____ / ____ / _____

Cycle regularity: _____

Men (if applicable)

Fertility concerns or prostate history: _____