Female Hormone Deficiency Questionnaire

Patient Information

- Name: Date of Birth: Age:
- Height: Weight:
- Phone number:
- Address:
- Preferred pharmacy:

Section 1: Menstrual and Reproductive History

1. Age at menarche (first period): _____
2. Are your periods regular? ☐ Yes ☐ No
    - If no, please describe: _____
3. Date of last menstrual period: _____
4. Have you had hysterectomy? ☐ Yes ☐ No
    - If yes, total or partial: _____
5. Number of pregnancies: _____
    - Number of live births: _____
    - Number of miscarriages: _____
    - Number of abortions: _____
6. History of infertility? ☐ Yes ☐ No
7. Menstrual symptoms (check all that apply):

☐ Heavy bleeding
☐ Light bleeding
☐ Painful periods
☐ Irregular cycles
☐ Absent periods
☐ Post menopause bleeding

8. Menopause status: ☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal
    - Age at menopause (if applicable): _____

Section 2: Symptoms Suggestive of Hormone Deficiency

A. Estrogen Deficiency

- Vaginal dryness ☐ Never ☐ Sometimes ☐ Often
- Pain during intercourse ☐ Never ☐ Sometimes ☐ Often
- Hot flashes ☐ Never ☐ Sometimes ☐ Often
- Night sweats ☐ Never ☐ Sometimes ☐ Often
- Sleep disturbances ☐ Never ☐ Sometimes ☐ Often
- Breast tenderness ☐ Never ☐ Sometimes ☐ Often
- Mood changes (irritability, depression, anxiety) ☐ Never ☐ Sometimes ☐ Often
- Memory or concentration problems ☐ Never ☐ Sometimes ☐ Often

B. Progesterone Deficiency

- Irregular periods ☐ Never ☐ Sometimes ☐ Often
- Spotting between periods ☐ Never ☐ Sometimes ☐ Often
- Bloating or breast tenderness before periods ☐ Never ☐ Sometimes ☐ Often

C. Testosterone Deficiency

- Low libido ☐ Never ☐ Sometimes ☐ Often
- Decreased energy ☐ Never ☐ Sometimes ☐ Often
- Muscle weakness ☐ Never ☐ Sometimes ☐ Often
- Decreased motivation ☐ Never ☐ Sometimes ☐ Often

D. Thyroid Hormone Deficiency

- Fatigue ☐ Never ☐ Sometimes ☐ Often
- Cold intolerance ☐ Never ☐ Sometimes ☐ Often
- Hair thinning or hair loss ☐ Never ☐ Sometimes ☐ Often
- Dry skin ☐ Never ☐ Sometimes ☐ Often
- Weight gain ☐ Never ☐ Sometimes ☐ Often
- Constipation ☐ Never ☐ Sometimes ☐ Often
- Puffy face or swelling ☐ Never ☐ Sometimes ☐ Often

Section 3: Bone, Joint, and Muscle Symptoms

- Joint pain ☐ Never ☐ Sometimes ☐ Often
- Muscle weakness ☐ Never ☐ Sometimes ☐ Often
- Osteoporosis or history of fractures ☐ Yes ☐ No
- Back pain ☐ Never ☐ Sometimes ☐ Often

Section 4: Cardiovascular Symptoms

- Palpitations ☐ Never ☐ Sometimes ☐ Often
- Dizziness or fainting ☐ Never ☐ Sometimes ☐ Often
- Swelling in legs ☐ Never ☐ Sometimes ☐ Often

Section 5: Gastrointestinal Symptoms

- Nausea ☐ Never ☐ Sometimes ☐ Often
- Bloating ☐ Never ☐ Sometimes ☐ Often
- Changes in appetite ☐ Never ☐ Sometimes ☐ Often

Section 6: Lifestyle and Risk Factors

- Diet (brief description): _____
- Exercise frequency: ☐ None ☐ 1–2 times/week ☐ 3–5 times/week ☐ Daily
- Alcohol consumption: ☐ None ☐ Occasionally ☐ Regularly
- Smoking status: ☐ Never ☐ Former ☐ Current
- Medication or supplement use (including hormones): _____
- Stress level: ☐ Low ☐ Moderate ☐ High

Section 7: Family and Medical History

- Family history of:
    - Menopause before age 45 ☐ Yes ☐ No
    - Breast Cancer ☐ Yes ☐ No

- Uterine Cancer ☐ Yes ☐ No
- Osteoporosis ☐ Yes ☐ No
- Thyroid disease ☐ Yes ☐ No
- Heart disease ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No

- Personal history of chronic illness: _____
  _____

Section 8: Psychological and Cognitive Symptoms

- Mood swings ☐ Never ☐ Sometimes ☐ Often
- Depression ☐ Never ☐ Sometimes ☐ Often
- Anxiety ☐ Never ☐ Sometimes ☐ Often
- Difficulty concentrating ☐ Never ☐ Sometimes ☐ Often
- Memory problems ☐ Never ☐ Sometimes ☐ Often

Section 9: Screening/GYN History

- Family history of:
  - First-degree relative with breast cancer ☐ Yes ☐ No
  - Family history of ovarian cancer ☐ Yes ☐ No
  - Family history of uterine cancer ☐ Yes ☐ No
  - Family history of early menopause ☐ Yes ☐ No
  - Family history of fibroids or endometriosis ☐ Yes ☐ No
  - Family history of DVT, PE, or known clotting disorders ☐ Yes ☐ No
  - Early cardiac disease mother/sisters ☐ Yes ☐ No
  - Family history of stroke ☐ Yes ☐ No
- Personal history of chronic illness_____
  _____
- Date and results of your last PAP and Mammogram:_____
  _____