# Female Hormone Replacement Therapy Questionnaire

NAME: _________________________________________________ Todays date: ______________

DOB: ___________________ Age: ________ Last Physical/Blood test: _____________________

Please list your main symptoms and concerns:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

What are your goals for therapy?

1.____________________________________________________________________________________

2.____________________________________________________________________________________

3.____________________________________________________________________________________

**<u>Personal Medical History</u>:** (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | Heart disease | | Bacterial/viral/fungal infections | | Celiac disease |
| | High blood pressure | | Arthritis | | Blood disease |
| | High cholesterol | | Headaches | | Alzheimer's disease |
| | Diabetes | | Depression | | Liver disease |
| | Cancer | | Anxiety | | Neurological disorders |
| | Thyroid disorders | | Fibromyalgia | | Altered Mood Changes |
| | Osteoporosis | | Gastric reflux | | Skin disorders |
| | Asthma/COPD | | IBS/Ulcerative colitis/Crohn's | | Autoimmune disease |
| | Migraine headaches | | Allergies (pets/seasonal/food) | | Anemia |

Do you smoke? □YES □NO if yes, how many packs a day? _________; for how many years? ______

Do you drink alcohol? □YES □NO if yes, type and weekly intake? ________________________________

Age of first menstruation: _________ First day of last menstrual period: ______________

Are you currently using contraception? _____________

Date of last Mammogram: _________ Pap smear ________ Bone Density: __________ Colonoscopy: _________

Have you had any of the following surgeries? Hysterectomy □YES □NO if yes, when? ______

Ovaries removed □YES □NO if yes, when? ______

**Present Symptoms**: (check all that apply)

As you have aged, have you experienced any of the following?

| | | | |
|---|---|---|---|
| | Decreasing muscle mass or flabbiness | | Increased anger or irritability |
| | Increased stiffness | | Reduced strength |
| | Decreased endurance | | Insomnia |
| | Significant weight gain | | Significant weight gain or loss |
| | Fluctuations in body temperature | | Increased body fat |
| | Night sweats | | Sensitivity to cold or heat |
| | Irritability | | Mood swings/changes |
| | Poor sleep | | Sleep difficulties |
| | Forgetfulness | | Unexplained depression/anxiety |

**Family medical history**: Has anyone in your family ever had any of the following?

□Heart Disease Relationship: ______________________________

□High Blood Pressure Relationship: ______________________________

□Cancer (type) Relationship: ______________________________

□Stroke Relationship: ______________________________

□Diabetes Relationship: ______________________________

□Renal Disease Relationship: ______________________________

□Osteoporosis Relationship: ______________________________

□High Cholesterol Relationship: ______________________________

**Hormone Therapy History:**

Are you currently or have you ever had Hormone Replacement Therapy? □YES □NO

If yes, what type of hormones?

□Estrogen □Progesterone □DHEA-S

□Thyroid □Cortisol □Testosterone

**Hormone related symptoms**: (check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| | Hot Flashes | | Decreased bone density | | Night sweats |
| | Urinary incontinence | | Thinning hair | | Irritability |
| | Painful intercourse | | Aches/pains | | Decreased libido |
| | Foggy thinking | | Frequent sleepiness | | Weight gain |
| | Cold body temperature | | Decreased height | | Nervous |
| | Vaginal Dryness | | Irregular periods | | Fatigue |
| | Sleep disturbances | | Depression | | Decreased work performance |
| | Mood changes | | Skin dryness | | Urine frequency/urgency |

Patient Signature______________________________ Date________________

Provider Signature______________________________ Date________________

**To be completed by office staff**

Mammogram Exam received □YES □NO

Pap smear Exam received □YES □NO

Bone Density Exam received □YES □NO

Colonoscopy Exam received □YES □NO