HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

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Name:_____ **Date**:_____

Menstrual History (as applicable):

Number of days between periods (from first day to first day) _____
Number of days of flow _____
Amount of flow (heavy, light, etc.) _____
Clots or pain (please describe) _____
Bleeding between periods- yes/ no
First day of last menstrual period _____

Prior use of hormones/contraception, if any: _____

Last mammogram: Date _____ Results _____
Last pap smear : Date _____ Results _____
Last pelvic ultrasound: Date _____ Results _____

Describe any recent lab work, radiology, etc. done by other providers: _____
_____
_____

Gynecological Past Medical History (have you ever had any of the following):

Abnormal pap smear- yes/ no
Breast lumps- yes/ no
Breast biopsy- yes/ no
Abnormal mammogram- yes/ no
Recurrent vaginal infections- yes/ no
Fibroid uterus- yes/ no
Hysterectomy- yes/ no

Personal Habits (list amounts of any of the following):

Alcohol _____ Caffeine _____
Current smoking _____ Former smoking _____
Exercise (include type) _____

Are you currently having any of the following? (please rate from none to severe):

	None				Severe
1. Hot flashes	0	1	2	3	4
2. Soaking night sweats	0	1	2	3	4
3. Daytime sweats	0	1	2	3	4
4. Palpitations	0	1	2	3	4
5. Fatigue	0	1	2	3	4
6. Depressed mood	0	1	2	3	4
7. Difficulty sleeping	0	1	2	3	4
8. Poor concentration	0	1	2	3	4
9. Poor memory	0	1	2	3	4
10. Poor functioning (work/home/school)	0	1	2	3	4
11. Headache	0	1	2	3	4
12. Anxiety/nervousness	0	1	2	3	4
13. Mood swings	0	1	2	3	4
14. Irritability	0	1	2	3	4
15. Decreased libido	0	1	2	3	4
16. Weight gain	0	1	2	3	4
17. Dry/irritated eyes	0	1	2	3	4

	None				Severe
18. Increased facial hair	0	1	2	3	4
19. Hair loss on top of head	0	1	2	3	4
20. Increase in facial wrinkles	0	1	2	3	4
21. Dry skin	0	1	2	3	4
22. Increase in belly fat	0	1	2	3	4
23. Decrease in pubic hair	0	1	2	3	4
24. Decrease in underarm hair	0	1	2	3	4
25. Decrease in fatty tissue in pubic area (0=padded >> 4= flat)	0	1	2	3	4
26. Vaginal irritation/burning/itching	0	1	2	3	4
27. Decreased vaginal secretions	0	1	2	3	4
28. Painful intercourse	0	1	2	3	4
29. Spotting/bleeding after intercourse	0	1	2	3	4
30. Increased urinary tract infections	0	1	2	3	4
31. Urinary incontinence	0	1	2	3	4

Please describe any other issues or concerns that you have:

_____
_____
_____-