Female Bio-Identical Hormone Replacement Questionnaire

Personal Data			
Name:		**Date:**	
Address:	**City:**	**State:**	**Zip:**
Home phone:	**Cell phone:**		**Work phone:**
Date of Birth:		**Age:**	
E-mail Address:			
Primary Care Physician			
Name:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**

Present Symptoms
Please briefly describe your symptoms.
What do you feel is the most important factor to your present symptoms?

Past Medical History	
Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.	
Date	Medical diagnosis, illness, accident

Past Surgical History	
Date	Surgery

Medications		
Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**		
Name of Medication	Dosage	Dosing schedule

Allergies
Are you allergic to ANY MEDICATIONS (prescription or over the counter)?

Family History		
Please list ALL illnesses (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, prostate, lung, skin, blood, etc…). If a member is deceased please list age at death and cause of death if known.		
Relationship	**Age**	**Medical problem/ Cause of death**
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History
Please remember this information is strictly confidential and will be used only to address your symptoms and/or complaints.

Do you smoke cigarettes now or have you in the past? ☐ Yes ☐ No

- If yes, how many packs per day? ___________
- How many total years have you smoked? ___________

Do you drink alcohol? ☐ Yes ☐ No

- If yes, how many drinks and what kind (wine, beer, bourbon, etc.)do you have in an average week? ____.

Do you now or have you in the past used any illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)? ☐ Yes ☐ No

- If yes, what substance and how often? ____

Gynecological History		
Date of last PAP smear? __________________ Physician who performed? _________________________ Date of last mammogram? ________________ Facility where performed? __________________________		
	YES	**NO**
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have? ___________________		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have? ___________________		
Have you ever had a pelvic ultrasound? If yes, why? What were the findings? ____		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you ever noticed breast skin or nipple changes?		
Are you using a birth control method? If yes, what kind?		
Are you still having menstrual periods? If yes, when was the first day of your last period? ________________________________		
Please describe any problems, if any, you have with your periods. Periods are/were ☐ regular ☐ irregular ☐painful ☐ crampy ☐ heavy ☐ light		
Age periods began: ____________ # days of bleeding ___________ cycle length ____________		
If you are no longer having periods, at what age did your periods stop? ________________ If your periods stopped less than one year ago, how many months ago was your last period? __________		
Did your periods stop because you had a hysterectomy? ☐ Yes ☐ No • If yes, what was the reason for the surgery? ____________________________________ • Were the ovaries removed at the same time? ☐ Yes ☐ No ☐ Not Sure		
If you were ever pregnant, what is the total number of _______ Children ________ Miscarriages _________ Therapeutic Abortions		
Do you have a history of any of the following cancers? ☐ Vulva ☐ Ovary ☐Other: ________________ ☐ Uterus ☐ Fallopian Tubes ________________ ☐ Vagina ☐ Breast ________________ ☐ Cervix ☐ Colon		

Estrogens Check which of these symptoms ate troublesome and have persisted over time.		
Estrogen Deficiency	**Estrogen and Progesterone Imbalance**	
☐ Hot Flashes	☐ Mood Swings	☐ Elevated Triglycerides
☐ Night Sweats	☐ Cystic Ovaries	☐ Breast Cancer
☐ Vaginal Dryness	☐ Tender Breast	☐ Low Libido
☐ Foggy Thinking	☐ Heavy Menses	☐ Infertility
☐ Memory Lapses	☐ Water Retention	
☐ Urinary Incontinence	☐ Sugar Craving	
☐ Tearful	☐ Nervousness	
☐ Depressed	☐ Irritable	
☐ Sleep Disturbances	☐ Anxious	
☐ Heart Palpitations	☐ Fibrocystic Breast	
☐ Bone Loss	☐ Headaches	
☐ Headaches	☐ Cold Body Temperature	
☐ Anxiety	☐ Uterine Fibroids	
☐ Panic Attacks	☐ Weight Gain- Hips	
☐ Urinary Tract Infection	☐ Bleeding Changes	

Androgens Check which of these symptoms are troublesome and have persisted over time		
Androgen Excess	**Androgen Deficiency**	
☐ Increased Facial Hair	☐ Low Libido	☐ Heart Palpitations
☐ Increased Body Hair	☐ Vaginal Dryness	☐ Headaches
☐ Acne	☐ Fatigue	☐Fibromyalgia
☐ Oily Skin	☐ Aches/Pains	☐Irritable
☐ Nervous	☐ Memory Lapses	☐ Thinning Skin
☐ Irritable	☐ Foggy Thinking	
☐ Anxious	☐ Urinary Incontinence	
☐ Depressed	☐ Depressed	
☐ Ovarian Cysts	☐ Anxious	
☐ Elevated Triglycerides	☐ Sleep Disturbances	
☐ Sleep Disturbances	☐ Bone Loss	
☐ Breast Cancer	☐ Decreased Muscle Mass	

DHEA Check which of these symptoms are troublesome and have persisted over time	
☐ My Hair is dry	☐ I don’t have much hair under my arm
☐ I don’t have much fatty tissue in the pubic area	☐ I don’t have much hair in my pubic area
☐ My eyes and skin are dry	
☐ My body doesn’t have much of a special scent during sex	
☐ My muscles are flabby	
☐ I can’t tolerate noise	
☐ My belly is getting fat	
☐ My libido is low	

Growth Hormone Check which of these symptoms are troublesome and have persisted over time	
☐ I often feel unwell	☐ I feel I am rapidly aging
☐ I get easily exhausted	☐ I am a light sleeper
☐ I feel lack of inner peace	☐ I excessively need at least 9 hours of sleep
☐ I have difficulty recovering when going to bed late	
☐ I feel chronically anxious	
☐ I often get a feeling of collapsing	
☐ I have a tendency to be depressed	
☐ I feel a lack of self control	
☐ I have outbursts of panic/anxiety	

Pregnenolone Deficiency Check which of these symptoms are troublesome and have persisted over time
☐ I have memory loss
☐ My joints hurt (fingers, wrists, elbows, ankles, knees)
☐ I'm feeling a bit drained and it's hard to handle stress
☐ I don't see colors as brightly as before
☐ I have lost interest/ appreciation for art
☐ I don't have much hair under my arms or pubic area
☐ I feel more tired at rest than when I am active
☐ I have abundant, light-colored urine during the day
☐ I have low blood pressure
☐ I crave salty foods

Adrenals Check which of these symptoms are troublesome and have persisted overtime.		
Cortisol Excess		**Cortisol Deficiency**
☐ Sleep Disturbances	☐ Heart Palpitations	☐ Fatigue Early During the Day
☐ Bone Loss	☐ Headaches	☐ Sugar Cravings
☐ Fatigue	☐ Stress	☐ Allergies
☐ Weight Gain- Waist	☐ Cold Body Temperature	☐ Chemical Sensitivity
☐ Loss of Muscle Mass	☐ Sugar Cravings	☐ Handle Stress Poorly
☐ Thinning Skin	☐ Low Libido	☐ Cold Body Temperature
☐ Elevated Triglycerides	☐ Hair Loss	☐ Irritable/ Angry
☐ Breast Cancer	☐ Increased Facial Hair	☐ Arthritis
☐ Irritable	☐ Increased Body Hair	☐ Heart Palpitations
☐ Anxious	☐ Acne	☐ Aches/ Pains
☐ Memory	☐ Nervous	☐ Repeated Illnesses

Thyroid Check which of these symptoms are troublesome and have persisted over time.	
Thyroid Excess	**Thyroid Deficiency**
☐ Heat Intolerance	☐ Cold Intolerance
☐ Voice has become hoarse	☐ Constipation
☐ Palpitations	☐ Fatigued/ Weakness
☐ Weight Loss	☐ Unexplained Weight Gain
☐ Tremors/ Shakiness	☐ Inability to Lose Weight
☐ Diarrhea	☐ Stressed
☐ Nervousness/ Anxious/ Panic Attacks	☐ Cold Body Temperature
☐ Muscle Weakness	☐ Irritable
☐ Difficulty Conceiving/ Infertility	☐ Lack of Motivation
☐ Coarse, Dry Skin	☐ Muscle Cramps
☐ Insomnia	☐ Aches/ Pains

System Review - Check the appropriate box for each question.			
Constitutional/ ID/ Oncology	**Yes**	**No**	**Not Sure**
Have you had unexplained weight loss?			
Do you have a hard time waking up in the morning?			
Do you often feel tired in the afternoon?			
Do you have any bone disorder problems?			
Do you have fever of chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
Respiratory			
Do you have a cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema?			

System Review – Check the appropriate box for each question.			
Cardiovascular	**Yes**	**No**	**Not Sure**
Do you have chest pains?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart condition?			
Have you ever been diagnosed with a blood clot?			
Gastrointestinal			
Do you have trouble swallowing food?			
Do you have nausea or vomiting			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or bloating?			
Have you ever been diagnosed with hepatitis or liver disease?			
Endocrine			
Do you urinate frequently or in larger amounts than usual?			
Do you have a greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne?			
Have you ever been diagnosed with a thyroid problem?			
Neurological			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you ever experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Physician Notes: