Bio-Identical Hormone Questionnaire (Female)

Personal Data

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____

Email: _____

Present Symptoms

Please briefly describe your concerns and/or symptoms:

Current Medical Conditions:

_____

_____

_____

Current Medications (include both prescription and over the counter):

_____

_____

_____

Hormone Therapy History

Hormone	Dose	Reason	Start Date	Stop Date

Medical History

(please check yes or no)

	Yes	No
Do you still have your period?		
If yes, the date of your last period?		
Do you have any difficulty with your periods (PMS, irregular, difficult)?		
If yes, please describe:		
Have you had a hysterectomy?		
If yes, when?		
Do you still have your ovaries?		
Do you have any personal or family history of cancer?		
If yes, what type (i.e., colon, breast, etc.)?		
Have you ever been diagnosed with any breast conditions, such as lumps or fibroids?		
Do you have a personal or family history of osteoporosis?		

Current Symptoms

	Absent	Mild	Moderate	Severe
Hot Flashes				
Night Sweats				
Vaginal Dryness				
Incontinence				
Bleeding Changes				
Fibrocystic Breasts				
Weight Gain				
Fluid Retention				

Current Symptoms (continued)

	Absent	Mild	Moderate	Severe
Dry Skin/Hair				
Hair Loss				
Anxiety				
Depression				
Mood Swings				
Irritability				
Stress				
Headaches				
Breast Tenderness				
Cramps				
Difficulty Falling Asleep				
Difficulty Staying Asleep				
Fatigue				
Loss of Memory				
Foggy Thinking				
Acne				
Arthritis				
Decreased Sex Drive				
Harder to Reach Climax				