Bio-Identical Hormone Replacement Questionnaire for Females

Name:_____Date:_____
Date of Birth:_____ Age:_____ Email:_____
Address:_____ City:_____ State:_____ Zip:_____
Home/Cell Phone:_____ Work Phone:_____
Occupation:_____ Employer:_____
What are the ages of your children:_____ How did you hear about us: _____

Briefly Describe Your Present Symptoms

_____
_____
_____

What do you feel is the most important factor to your present symptoms?

_____
_____
_____

Medical History – List all medical problems or illnesses you have or have had; include hospitalizations for illnesses or accidents.

Date	Describe the Medical Diagnosis – was this an Illness or an Accident

Surgical History

Date	Surgery

Medications – List ALL prescription medications and ALL over the counter medications including supplements and vitamins

Name of Medication	Dosage	Schedule

Name of Medication	Dosage	Schedule

Allergies to Medications – List **ALL MEDICATIONS** (prescriptions or over the counter) you are allergic to

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Family History – List ALL illnesses (heart disease, stroke, diabetes, hypertension, cancer of any type), etc.

Relationship	**Age when occurred**	**Medical Problem (If Death occurred list Problem and age at time of Death)**
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History – This information is strictly confidential and will be used only to address 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 years have you, or did you smoke? _____
Do you drink alcohol? Yes____ No____ If yes, how many drinks do you usually have in a week? _____ What do you usually drink (beer, wine, bourbon, etc.)? _____
Do you now, or have you ever used illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)? Yes____ No____ If yes, what substance and how often? _____

Gynecological History

Date of last PAP smear: _____ Date of last mammogram: _____
Physician: _____ Facility: _____
Physician's Phone #_____ Facility's Phone #_____
Describe any problems, if any, you have with your periods: _____

Have you ever had an abnormal PAP smear? If yes, what was the abnormality and follow up you had? _____	Yes____	No____
Have you ever had an abnormal mammogram? If yes, what was the abnormality and follow up you had? _____	Yes____	No____
Have you ever had a breast biopsy?	Yes____	No____
Have you ever had a cervical biopsy?	Yes____	No____
Have you noticed breast skin or nipple changes?	Yes____	No____
Have you noticed any lumps in your breasts?	Yes____	No____
Are you using a birth control method? If yes, what kind? _____	Yes____	No____
Are you still having menstrual periods? If yes, what was the date of the first day of you last period? _____	Yes____	No____
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____		

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Do you have a history of any of the following **cancers**?

Vulva	Cervix	Breast
Uterus	Ovary	Colon
Vagina	Fallopian Tube	Other

Hormone Therapy History – If you have ever been treated with hormone replacement, either prescription or over the counter, please list and give reason for treatment.

Hormone	Dose	Reason	Start Date	Stop Date

Estrogen - Check which of these symptoms are troublesome and have persisted over time:

Estrogen Deficiency

Hot Flashes	
Night Sweats	
Vaginal Dryness	
Foggy Thinking	
Memory Lapses	
Urinary Incontinence	
Tearful	
Depressed	
Sleep Disturbances	
Headaches	
Bone Loss	

Estrogen Excess / Progesterone Deficiency

Mood Swings(PMS)	
Cystic Ovaries	
Tender Breasts	
Heavy Menses	
Water Retention	
Sugar Cravings	
Nervousness	
Irritable	
Anxious	
Bleeding Changes	
Low Libido	

Androgens - Check which of these symptoms are troublesome and have persisted over time

Androgen Excess Androgen Deficiency

Increased Facial Hair		Anxious	
Increased Body Hair		Depressed	
Acne		Ovarian Cysts	
Oily Skin		Elevated Triglycerides	
Nervous		Sleep Disturbances	
Irritable/Irritable			

Androgen Deficiency

Low Libido		Anxious/Irritable	
Vaginal Dryness		Sleep Disturbances	
Fatigue		Thinning Skin	
Aches/Pains		Decreased Muscle Mass	
Memory Lapses		Headaches	
Foggy Thinking			
Depressed			

Adrenals - Check which of these symptoms are troublesome and have persisted over time.

Cortisol Excess

Sleep Disturbances		Memory	
Sugar Cravings		Increased Facial/ Body Hair	
Fatigue		Headaches	
Weight Gain - Waist		Stress	
Loss of Muscle Mass		Cold Body Temperature	
Thinning Skin		Hair Loss	
Elevated Triglycerides			
Low Libido			
Irritable/Anxious/Nervous			
Acne			

Cortisol Deficiency

Fatigue	
Sugar Craving	
Allergies	
Chemical Sensitivity	
Stress	
Cold Body Temperature	
Irritable	
Arthritis	
Aches/Pains	

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Thyroid - Check which of these symptoms are troublesome and have persisted over time.

Thyroid Excess	
Heat Intolerance	
Insomnia	
Palpitations	
Weight Loss	
Tremors/Shakiness	
Diarrhea	
Nervousness/Anxious/Panic Attacks	
Muscle Weakness	
Difficulty Conceiving/Infertility	
Coarse Dry Skin	

Thyroid Deficiency	
Cold Intolerance	
Constipation	
Fatigue/Weakness	
Unexplained Weight Gain	
Inability to Lose Weight	
Lack of Motivation	

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 fever of chills?			
Do have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive of HIV?			
Have you ever had a sexually transmitted disease?			

Respiratory	YES	NO	Not Sure
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			
Cardiovascular	**YES**	**NO**	**Not Sure**
Do you have chest pain?			
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	**YES**	**NO**	**Not Sure**
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 swelling?			
Have you ever been diagnosed with hepatitis or liver disease?			

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Endocrine	YES	NO	Not Sure
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	**YES**	**NO**	**Not Sure**
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experience double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
Urologic / Renal	**YES**	**NO**	**Not Sure**
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?			

MEDICAL HISTORY QUESTIONNAIRE: Patient will submit a truthful, accurate, and complete Medical History Questionnaire. Patient also acknowledges that failure to provide accurate, truthful, and complete information on this Questionnaire to the Physician(s) of Physician's Weight Control and Wellness Centers could result in inappropriate treatment. _____
Initial

(All information contained in this questionnaire is strictly confidential, will be protected to the highest of HIPAA standards, and will become part of your PWCWC medical record.)

Patient's Signature_____ Date_____

Physician's Signature_____ Date_____

Doctor's Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____