Women's Hormone Consultation Questionnaire

Please fill out your information

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Full Name

Phone (Home) Phone (Cell) Email

Best Time to Contact Address

Referred by:

☐ Doctor ☐ Friend/Family ☐ Self ☐ Other:

If Doctor, please provide Doctor Name:

Date of Birth Age Occupation

Employment

☐ Part Time ☐ Full Time
☐ Retired ☐ Unemployed
☐ Other:

Height Weight Waist Size BMI

Have you had a hysterectomy?

☐ Yes ☐ No

If so, when?

Do your ovaries remain?

☐ Yes ☐ No

How did you arrive at the decision to consider Bio-identical Hormone Replacement Therapy?

What are your goals with taking BHRT?

What is your level of stress?

☐ Low ☐ Moderate ☐ High

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Patient Medical Information

Allergies

- ☐ Penicillin
- ☐ Codeine
- ☐ Dye Allergies
- ☐ Food Allergies
- ☐ Morphine
- ☐ Sulfa Drugs
- ☐ Seasonal (Pollen)
- ☐ Nitrate Allergies
- ☐ Aspirin
- ☐ No Known Allergies

Please list any food allergies:

Please describe the allergic reaction you experienced when it occurred.

Medical Conditions/Diseases (Past and Present) Check all that apply to you.

- ☐ Heart Disease (ex. Congestive Heart Failure)
- ☐ High Blood Pressure (ex. Hypertension)
- ☐ Fibromyalgia
- ☐ Autoimmune Issue
- ☐ Uterine fibroids
- ☐ Arthritis
- ☐ Hormonal Related Issues
- ☐ Eye Disease (Glaucoma, etc.)
- ☐ Depression
- ☐ Blood Clotting Problems
- ☐ Broken bones
- ☐ Endometriosis
- ☐ High Cholesterol or lipids (ex. Hyperlipidemia)
- ☐ Thyroid Disease
- ☐ Headaches/Migraines
- ☐ Fibrocystic breasts
- ☐ Diabetes or Insulin Resistance
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Lung Condition (Asthma, Emphysema,)
- ☐ Ulcers (stomach, esophagus)
- ☐ Epilepsy
- ☐ Surgeries
- ☐ Others

Please explain your medical conditions (autoimmune type, arthritis type, cancer type, etc.)

Medications taken:

Hormones previously taken:

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Over the Counter (OTC) Issues:

- ☐ Pain Reliever
- ☐ Sleep aids (ex. Excedrin PM®, Unisom®)
- ☐ Antidiarrheals (ex. Imodium®, Kaopectate®)
- ☐ Acetaminophen (Tylenol®)
- ☐ Antacids (ex. Maalox®, Mylanta®)
- ☐ Ketoprofen (ex. Orudis KT®)
- ☐ Naproxen (ex. Aleve®)
- ☐ Antihistamine Products (ex. Chlor-Trimenton®)
- ☐ Other: please specify:
- ☐ Combination product cough+cold reliever
- ☐ Aspirin
- ☐ Laxatives/Stool Softeners (Correctol®)
- ☐ Diet Aids/Weight Loss Products (Dexatrim®)
- ☐ Ibuprofen (Motrin IB®)
- ☐ Acid Blockers (ex. Pepcid AC®, Zantac®)
- ☐ Cough Suppressant (ex. Robitussin DM®)
- ☐ Decongestant Product (ex. Sudafed®)

Please indentify vitamins you are using (ex. B Complex, E, C, Beta Carotene)

Please Identify Minerals you are using (ex. Calcium, Magnesium, Chromium)

Please Identify Herbs you are using (ex. Ginseng, Gingko Biloba, Herbal Medicinal Teas)

Please Identify Nutrition/Protein Supplements you are using (Amino Acids, Fish Oil)

Please Identify Enzymes you are using (ex. Digestive Formulas, Papaya, CoEnzyme Q10)

Others (ex. Glucosamine)

Mammography

☐ Yes ☐ No

If so, what the date and result of Mammography?

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Patient Medical Information

Cholesterol Level

☐ Yes ☐ No

If so, what the date and result of Cholesterol test?

Bone Density

☐ Yes ☐ No

If so, what the date and result of Bone Density test?

Do you use tobacco?

☐ Yes ☐ No

If so, how often and how much?

Do you use alcohol?

☐ Yes ☐ No

If so, how often and how much?

Do you use caffeine?

☐ Yes ☐ No

If so, how often and how much?

Do you get routine physical exercise?

☐ Yes ☐ No

If so, what type?

List any dietary restrictions:

Meal Choices

Breakfast

Lunch

Dinner

Snacks

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Do you have a family history of any of the following?

Uterine Cancer ☐ Yes ☐ No
If so, which family members?

Ovarian Cancer ☐ Yes ☐ No
If so, which family members?

Breast Cancer ☐ Yes ☐ No
If so, which family members?

Heart Disease ☐ Yes ☐ No
If so, which family members?

Osteoporosis ☐ Yes ☐ No
If so, which family members?

Thyroid Disorder ☐ Yes ☐ No
If so, which family members?

Autoimmune Disorder ☐ Yes ☐ No
If so, which family members?

Prostate Cancer ☐ Yes ☐ No
If so, which family members?

Age at first period

Date of last period

Date of last PAP smear

PAP smear results:

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Patient Medical Information

Have you ever had an abnormal PAP?
☐ Yes ☐ No

If so, what was the treatment?

Are you sexually active?
☐ Yes ☐ No

Are you trying to get pregnant? How long?
☐ Yes ☐ No

Any current birth control methods and any issues (if so, how long?)

Past birth control and any related problems

How many days from start of one period to the start of next?

Number of days flow

Amount of bleeding

Amount of cramps

Premenstrual symptoms

Starting and ending when:

Any current changes in your normal cycle?
☐ Yes ☐ No

Any bleeding between periods?
☐ Yes ☐ No

If so, when?

Any unusual vaginal discharge or itching?
☐ Yes ☐ No

If so, what treatment?

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Age at first pregnancy

How many full-term pregnancies?

Any problems?

Any interrupted pregnancies? (miscarriages or abortions)

☐ Yes ☐ No

Have you had tubal ligation?

☐ Yes ☐ No

If so, when?

Have you had any part of whole ovary removed?

☐ Yes ☐ No

If so, when?

Please check any or all symptoms that apply

- ☐ Memory Lapse
- ☐ Incontinence
- ☐ Increased Urinary Urge
- ☐ Heart Palpitations
- ☐ Rapid Heart Beat
- ☐ Bleeding Cycle Changes
- ☐ Breast Tenderness
- ☐ Nervousness
- ☐ Emotional Instability
- ☐ Infertility Issues
- ☐ Decreased Libido
- ☐ Hearing Loss
- ☐ Decreased Stamina
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Loss of Scalp
- ☐ Slow Pulse Rate
- ☐ Depression
- ☐ Puffy Eyes/Face
- ☐ Dry Skin
- ☐ Goiter
- ☐ Foggy Thinking
- ☐ Hot Flashes
- ☐ Cramps
- ☐ Thinning Skin
- ☐ Mood Swings
- ☐ Fluid Retention
- ☐ Weight Gain - Hips
- ☐ Weight Gain - Waist
- ☐ Anxiety
- ☐ Acne
- ☐ Allergies
- ☐ Aches and Pains
- ☐ Low Blood Sugar
- ☐ Rapid Aging
- ☐ Morning Fatigue
- ☐ Evening Fatigue
- ☐ Headaches
- ☐ High Cholesterol
- ☐ Dry or Brittle hair
- ☐ Constipation
- ☐ Decreased Sweating
- ☐ Bone Loss
- ☐ Stress
- ☐ Night Sweats
- ☐ Irritability
- ☐ Cravings for Salt
- ☐ Cravings for Sweets
- ☐ Vaginal/Urinary Tract Infection
- ☐ Insomnia (Falling Asleep)
- ☐ Sleep Disturbances (Interrupted Sleep)
- ☐ Vaginal Dryness/Atrophy
- ☐ Harder to Reach Climax
- ☐ Decreased Muscle Size/Strength
- ☐ Increased Facial or Body Hair
- ☐ Sensitivity to Chemicals
- ☐ Caffeine or Nicotine Needs
- ☐ Cold Extremities
- ☐ Sensitivity to Cold
- ☐ Low(cold) body temperature
- ☐ Elevated Triglycerides
- ☐ Swelling of Ankles/Wrists
- ☐ Brittle or Breaking Nails

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Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (Rx BHRT), other medications, or any other questions that come up as you read through the materials you have received. Bring this question sheet with you to your consultation so you can discuss this information with your pharmacist. Thank you.

COMMUNICATION CONSENT

Would you like to permit anyone to have access to information?

☐ Yes ☐ No

Please list any persons to whom we are permitted to give information to (give name and relationship).

Name and Relationship

Name

Date

Signature