BIOIDENTICAL HORMONE REPLACEMENT QUESTIONAIRE

Name of Patient: ______________________________________ DOB: ______________________

Address: _____________________________ City/State: ________________________ Zip: _____________

Home: ________________________Work: _____________________ Cell: _________________________

E-Mail: ____

Height:________________ Weight:_______________ Personal weight goal:__________________

PERSONAL OVERVIEW

Are you still menstruating? YES NO

Date of last Menstrual Period: ________________

How regular are your menstrual periods? ____

Do you still have your ovaries? YES NO

Do you still have your uterus? YES NO Date of surgery: _____________ Reason: ______________

How many pregnancies have you experienced? _________

How many children have you had? _________

At what age did your mother reach menopause? __________

At what age did your sisters reach menopause? ___________

List any allergies you have:

Foods: ____

Medications: ____

Other: ____

Are you lactose intolerant? YES NO

PREVIOUS EXPERIENCE WITH HRT THERAPY

Discuss any previous Hormone Replacement Therapy:

Start Date: _________________ What did you try? __________________________________

What did you like? ____

What did you dislike? ____

Reasons for discontinuing: ____

PERSONAL MEDICAL HISTORY

Please indicate any previous or current medical conditions and the date of diagnosis:

YES	NO	MEDICAL CONDITION	DATE OF DIAGNOSIS
		Angina/Chest Pain	
		Anxiety	
		Blood Clot	
		Bone Fracture	
		Cancer	
		Depression	
		Endometriosis	
		Fibrocystic Breast Disease	
		Heart Attack	
		Heart Disease	
		High Blood Pressure	
		Lupus	
		Migraine	
		Obesity	
		Rheumatoid Arthritis	
		Osteoporosis	
		Prematurely Gray	
		Sleep Apnea	
		Other	

FAMILY MEDICAL HISTORY

Please indicate any previous or current medical conditions and the relationship to the person:

YES	NO	MEDICAL CONDITION	RELATIONSHIP	AGE OF DIAGNOSIS
		Angina/Chest Pain		
		Anxiety		
		Blood Clot		
		Bone Fracture		
		Cancer		
		Depression		
		Endometriosis		
		Fibrocystic Breast Disease		
		Heart Attack		
		Heart Disease		
		Lupus		
		Migraine		
		Obesity		
		Rheumatoid Arthritis		
		Osteoporosis		
		Prematurely Gray		
		Sleep Apnea		
		Other		

PERSONAL MENSTRUAL OVERVIEW

Adolescence

Age at which menstrual period began: ____________

How would you describe your menstrual cycle?

Light Moderate Heavy Unbearable

How would you describe your physical or emotional condition one week before your cycle?

____

Adulthood

Age at which menstrual period began: ____________

How would you describe your menstrual cycle?

Light Moderate Heavy Unbearable

How would you describe your physical or emotional condition one week before your cycle?

____

If you currently have your menstrual cycle, is it the same as listed above? YES No

Are you currently sexually active? YES NO

Are you satisfied with your current sexual activity? YES NO

What would you like to change about your sexual activity? _____________________________________

Have you previously taken oral contraceptives? YES NO

Name: ____

How long: ____

Issues with use: ____

CURRENT PRESCRIPTION MEDICATIONS

Medication	Reason	Duration of Treatment	Prescribing Physician

CURRENT NON-PRESCRIPTION MEDICATIONS

Medication	Reason	Duration of Treatment	Prescribing Physician

CURRENT VITAMIN/MINERAL/HERBAL SUPPLEMENTS AND MEDICATIONS

Medication	Reason	Duration of Treatment	Prescribing Physician

PERSONAL SLEEP HABITS

Please indicate any of the following symptoms that describe your sleep habits:

SLEEPHABITS	YES	NO	FREQUENCY
Snore, gasp, stop breathing			
Fight off sleep while driving			
Fight off sleep while reading			
Fight off sleep while watching TV			
Fight off sleep while working			
Have trouble falling asleep			
Have trouble staying asleep			
Wake up and cannot fall back asleep			
Experience daytime fatigue			
Does your bed partner complain of your snoring?			

Have you been diagnosed with sleep apnea? YES NO

When were you diagnosed? ___________________

Is it currently treated? YES NO How? __________________ How often? ________________

How many hours do you sleep per night?

PERSONAL LIFESTYLE COSNIDERATIONS

Please list current major stressors/obstacles to daily living:

____
____

Describe how you spend your leisure time:

____
____

Describe your exercise activities:

____
____

How healthy would you describe your daily diet?

____
____

PERSONAL DIET CONSIDERATION

How often do you consume the following items?

	DAILY	WEEKLY	MONTHLY	NEVER
Alcohol				
Caffeine				
Spicy Foods				
Tobacco				

List your food intake for the last three days:

Breakfast Lunch Dinner Snack

1 ____

2 ____

3 ____

PERSONAL SYMPTOM SURVEY

Please rate from 1 (never) to 5 (most severe) the following symptoms:

SYMPTOM	**1**	**2**	**3**	**4**	**5**	**FREQUENCY**
Anxiety						
Bloating						
Depression						
Fuzzy Thinking						
Headache						
Incontinence						
Low Sex Drive						
Moodiness						
Swollen Breasts						
Cramps						
Emotional Swings						
Painful Breasts						
Early Menstruation						
Headache						
Heart palpitations						
Hot flashes						
Insominia/Sleep Disturbances						
Night Sweats						
Painful Incontinence						
Shortness of Breath						
Short Term Memory Loss						
Tearfulness						
Vaginal Dryness						
Dry Skin						
Inability to Reach Orgasm						
Lack of Menstruation						
Breast Swelling						
Cold Hands/Feet						
Cravings for Sweets						
Fatigue						
Fibrocystic Breasts						
Water Retention						
Weight Gain						

PERSONAL SYMPTOM SURVEY (CONTINUED)

Please list any other bothersome symptoms that you like to fix:

____
____
____

Which three symptoms would you like to fix as soon as possible?

____
____
____

What are your personal goals with taking BHRT?

____
____
____

What is the best way for us to contact you? (Phone, E-Mail, etc.)

____

May we leave you a voicemail? YES NO

Patient Signature: ____ Date: __________________

Patient Name (printed): ____

QUESTION DOCUMENTATION FORM

Please write down any questions you may have about Prescription Bio-Identical Hormone Replacement Therapy (RxBHRT), other medications, or any other questions that come up as you read through the materials you have received.

1.

2.

3.

4.

5.