

Name: _____ DOB: _____ Date: _____

History and Health Questionnaire for Hormone Replacement

To what degree do you *currently* experience the following?

	N/A	None	Mild	Moderate	Severe
Difficulty Concentrating					
Can't Sleep					
Depressed or Unhappy					
Anxiety					
Headaches					
Moodiness/Emotional Swings					
Painful or Swollen Breasts					
Weight Gain					
Bloating					
PMS					

	N/A	None	Mild	Moderate	Severe
Night Sweats					
Difficulty with Memory					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Incontinence					
Frequent Urinary Infections					
Painful Intercourse					

	N/A	None	Mild	Moderate	Severe
Lack of Sexual Desire					
Fatigue/Loss of Energy					
Loss of Muscle/Strength					

Current Height: _____ Current Weight: _____

Current Medications/Supplements: _____

Allergies: _____ Family history of Cancer? _____

Date and result of last cholesterol: _____

Females Only

Do you still have periods? _____

If yes, are they regular? _____ Date of last period _____

If irregular, please describe: _____

Are you *currently* taking hormone replacement? _____

If yes, what? _____

Have you taken hormone replacement in the past? _____

If yes, *what, how long, why did you stop?* _____

Date and result of last mammogram: _____ Date of last pap: _____

Date and result of last bone density test: _____ History of Osteoporosis? _____

Please circle if you are affected by or have any of the following:

- Fibroids Endometriosis Abnormal Vaginal Bleeding Acne