Bio-Identical Hormone Questionnaire (Female)

Personal Data

Name:_____ Date:_____.

Address:_____City:_____ State:_____ Zip:_____.

Home Phone: _____Cell Phone: _____.

Date of Birth: _____ Referring Prescriber: _____.

Email: _____.

Present Symptoms

Please briefly describe your concerns and/or symptoms:

Current Medical Conditions:

Current Medications:

Hormone Therapy History

Hormone	Dose	Reason	Start Date	Stop Date

Medical History

(please check yes or no)

	Yes	No
Do you still have a period? If yes please describe:		
Do you have any difficulty with your periods (PMS, irregular, difficult)? If yes please describe:		
Have you had a hysterectomy?		
Do you still have your ovaries?		
Do you have any personal or family history of cancer? If yes what type (ie colon, brease 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				
Dry Skin/Hair				
Hair Loss				
Anxiety				
Depression				
Mood Swings				
Irritability				
Headaches				
Breast Tenderness				
Cramps				
Sleep Disturbances				
Fatigue				
Loss of Memory				
Foggy Thinking				
Acne				
Arthritis				
Low Libido				
Stress				