FEMALE HORMONE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential.

CONTACT & PERSONAL INFORMATION

Please review our policies on making recommendations in the "Getting Started" section located in the Resources tab on our website.

Name: _____ Date of Birth: MM ___ DD ___ YYYY ___

Address: _____ City/Town: _____

State/Province: _____ ZIP/Postal Code: _____

Email Address: _____ Height (in): _____ Weight (lbs): _____

PHONE NUMBER(s)

Home: _____ Mobile: _____

ALLERGIES TO MEDICATIONS OR FOODS (DRUG/FOOD NAME & REACTION EXPERIENCED)

INSURANCE INFORMATION

Insurance Company: _____ Insurance ID#: _____

Rx Group #: _____ Rx Bin #: _____ Rx PCN: _____

Doctor's Name: _____ Doctor's Phone: _____

WHAT ARE YOUR MAIN REASONS FOR SEEKING CARE?

ARE YOU TAKING HORMONES? IF SO WHAT IS YOUR REGIMEN?

LIST ANY PREVIOUS HORMONE THERAPY YOU HAVE TRIED

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS, NUTRITIONAL OR NATURAL PRODUCTS YOU ARE CURRENTLY TAKING

SURGERY AND MEDICAL HISTORY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?

☐ Hysterectomy ☐ Ovaries Removed ☐ Ablation

HYSTERECTOMY DATE (IF APPLICABLE)

MM ___ DD ___ YYYY ___

OVARY REMOVAL DATE (IF APPLICABLE)

MM ___ DD ___ YYYY ___

ABLATION DATE (IF APPLICABLE)

MM ___ DD ___ YYYY ___

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD PREVIOUSLY OR CURRENTLY

☐ Thyroid disease ☐ High cholesterol ☐ Osteoporosis ☐ Blood clotting disorder ☐ Lupus/Fibromyalgia/ Autoimmune disease

☐ Fibrocystic breast disease ☐ Heart disease ☐ Cancer ☐ High blood pressure ☐ Type 2 Diabetes

☐ Endometriosis ☐ Stroke ☐ Type 1 Diabetes ☐ Headaches/Migraines ☐ Other: _____

IS THERE A FAMILY HISTORY OF..?

☐ Uterine cancer ☐ Osteoporosis ☐ Breast cancer ☐ Ovarian cancer ☐ Heart disease

IF YOU HAVE A FAMILY HISTORY OF ABOVE, WHAT'S THEIR RELATION TO YOU?

DO YOU STILL HAVE YOUR PERIOD?

IF YOU STILL HAVE REGULAR PERIODS, WHAT WAS THE DATE OF YOUR LAST PERIOD?

MM DD YYYY

HAVE YOU HAD A MAMMOGRAM?

☐ Yes ☐ No

(IF YES) WITHIN THE LAST 12 MONTHS, WHEN WAS THE DATE? (IF YOU HAVE NOT HAD A MAMMOGRAM AND NEED TO BYPASS THIS QUESTION, PLEASE INDICATE FIELD WITH DATE OF 01/01/1900.)

MM DD YYYY

HAVE YOU HAD A BONE DENSITY TEST WITHIN THE LAST 3 YEARS?

☐ Yes ☐ No

DO YOU OR DID YOU HAVE PMS OR PMDD?

☐ Yes ☐ No

DO YOU HAVE CRAMPS?

☐ Yes ☐ No

HAVE YOU EVER TAKEN BIRTH CONTROL PILLS? IF YES, WHICH ONE?

☐ Yes ☐ No Pill Name: _____

DO YOU USE ALCOHOL? IF YES HOW MUCH?

☐ Yes ☐ No Alcohol Consumption: _____

RATE THE FOLLOWING IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS RECENTLY

	0 None	1 Mild	3 Moderate	4 Severe
Sleep disruption/Insomnia	○	○	○	○
Decreased libido (sex drive)	○	○	○	○
Night sweats	○	○	○	○
Depression	○	○	○	○
Fluid retention	○	○	○	○
Vaginal drynes	○	○	○	○
Migraines/headaches	○	○	○	○
Irritability	○	○	○	○
New facial hair	○	○	○	○
Nervousness/anxiety	○	○	○	○
Decreased quality of orgasm or intercourse	○	○	○	○
Hot flashes	○	○	○	○
Breast tenderness	○	○	○	○
Dry skin	○	○	○	○

	0 None	1 Mild	3 Moderate	4 Severe
Mood swings	○	○	○	○
Crying easily	○	○	○	○
Weight gain	○	○	○	○
Short term memory loss	○	○	○	○
Painful intercourse	○	○	○	○
Poor concentration	○	○	○	○
Food cravings	○	○	○	○
Backaches	○	○	○	○
Hair loss	○	○	○	○
Fatigue	○	○	○	○
Acne	○	○	○	○
Oily skin	○	○	○	○
Dry eyes	○	○	○	○
Decreased muscle mass	○	○	○	○
Bleeding changes or disorders	○	○	○	○
Heart palpitations	○	○	○	○
Brittle or breaking nails	○	○	○	○
Thinning of skin	○	○	○	○

DO YOU USE TOBACCO PRODUCTS?

☐ Yes. If so, we will need a signed release form from your current physician before we can participate in a recommendation.

☐ No

DO YOU GET PHYSICAL EXERCISE? IF YES, WHAT TYPE AND HOW OFTEN?

DO YOU HAVE ANY QUESTIONS/COMMENTS OR CONCERNS REGARDING NATURAL HORMONE REPLACEMENT THERAPY?

HOW DID YOU HEAR ABOUT US?

☐ Radio ☐ TV Channel 9 ☐ Facebook ☐ Invitation in Mail ☐ YouTube

☐ TV Channel 41 ☐ Website ☐ Other