

## FEMALE HORMONE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential

HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?  Hysterectomy  Ovaries Removed  Ablation  OVARY REMOVAL DATE (IF APPLICABLE)  MM  DD  YYYY  ABLATION DATE (IF APPLICABLE)  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?	AN QUESCIONS CONTAINED IN LINS QUESCIONNAITE ARE SCHOOLY CONTINUENCIAL.
Name:	
Address:   City/Town:   State/Province:   ZIP/Postal Code:   Email Address:   Height (in):   Weight (lbs):   PHONE NUMBER(S) Home:   Mobile:   ALLERGIES TO MEDICATIONS OR FOODS (ORUG/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?  ILIST 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  BURGERY AND MEDICAL HISTORY IN questions contained in this questionation are optional and will be legit circity confidential. HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?   HYSTERECTOMY DATE (OF APPLICABLE)   Mill	
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Email Address:	Address: City/Town:
PHONE NUMBER(S)  Home:	State/Province: ZIP/Postal Code:
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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					
(IF YES) WITHIN THE LAST 12 MONTHS, W DATE? (IF YOU HAVE NOT HAD A MAMMOG						
HAVE YOU HAD A MAMMOGRAM?	NEED TO BYPAS FIELD WITH DA	SS THIS QUES	TION, PLEASE I			
Yes No	MM DD					
HAVE YOU HAD A BONE DENSITY TEST WITHIN THE LAST 3 YEARS?	DO YOU OR DID YOU HAVE PMS OR PMDD?					
Yes No	Yes		No			
DO YOU HAVE CRAMPS?	HAVE YOU EVE YES, WHICH O		RTH CONTROL	PILLS? IF		
Yes No	Yes	No Pill Na	me:			
DO YOU USE ALCOHOL? IF YES HOW MUCH?						
Yes No Alcohol Consumption:						
RATE THE FOLLOWING IF YOU HAVE EXPERIENCED ANY O	F THE FOLLOWING O None	SYMPTOMS 1 Mild	RECENTLY 3 Moderate	4 Severe		
Sleep disruption/Insomnia				TOUVEIC		
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						

	O 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 participate in a recommendation.	t physician befo	ore we can	No				
DO YOU GET PHYSICAL EXERCISE? IF YES, WHAT TYPE AND HOW OFTEN?							
DO YOU HAVE ANY QUESTIONS/COMMENTS OR CONCERNS REGA	ARDING <u>Natur</u>	RAL HORMON	E REPLACEMEN	T THERAPY?			
HOW DID YOU HEAR ABOUT US?							
Radio TV Channel 9 Facebook Invitation in Mail YouTube							
TV Channel 41 Website Other							