

HORMONE ASSESSMENT QUESTIONNAIRE

NAME: _____

FIRST DAY OF LAST PERIOD -OR- LAST YEAR IF POSTMENOPAUSAL: _____

DO YOU HAVE PROBLEMS WITH:

HOT FLASHES / NIGHT SWEATS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	DIFFICULTY FALLING OR STAYING ASLEEP?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
IRREGULAR OR HEAVY MENSTRUAL PERIODS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	MOOD SWINGS / IRRITABILITY?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
VAGINAL DRYNESS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	ANXIETY / DEPRESSION?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
PAIN WITH INTERCOURSE?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	DECREASED LIBIDO / INTEREST IN SEX?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
FATIGUE / LACK OF ENERGY?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	DIFFICULTY REACHING SEXUAL CLIMAX?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
LOW BODY TEMPERATURE?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	DIFFICULTY LOOSING OR MAINTAINING WEIGHT?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
EXCESSIVE HAIR LOSS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	DIFFICULTY WITH CONCENTRATION/MEMORY?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
DRY SKIN / HAIR?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	MULTIPLE JOINT ACHES / PAINS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
ERECTILE DYSFUNCTION? (MEN)	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	CRAVINGS FOR SWEETS?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

HOW LONG HAVE YOU EXPERIENCED SYMPTOMS? _____

DO YOU CURRENTLY TAKE ANY OF THE FOLLOWING:

CALCIUM VITAMIN D ESTROGEN PROGESTERONE TESTOSTERONE DHEA OTHER HORMONES OR SUPPLEMENTS:

(describe/list) _____

HAVE YOU TAKEN HORMONE REPLACEMENT IN THE PAST? PLEASE EXPLAIN:

DO YOU HAVE ANY FAMILY HISTORY OF THE FOLLOWING?

<input type="checkbox"/> BREAST CANCER	FAMILY MEMBERS	_____
<input type="checkbox"/> OVARIAN CANCER	FAMILY MEMBERS	_____
<input type="checkbox"/> UTERINE CANCER	FAMILY MEMBERS	_____
<input type="checkbox"/> OSTEOPOROSIS	FAMILY MEMBERS	_____
<input type="checkbox"/> THYROID DISEASE	FAMILY MEMBERS	_____
<input type="checkbox"/> HEART DISEASE	FAMILY MEMBERS	_____
<input type="checkbox"/> OTHER CANCER	FAMILY MEMBERS	_____

ARE YOU INTERESTED IN BIOIDENTICAL HORMONE REPLACEMENT THERAPY? YES NO

HOW DID YOU LEARN ABOUT BIOIDENTICAL HORMONE REPLACEMENT THERAPY?

FRIEND

FAMILY MEMBER

DOCTOR / HEALTH CARE PROVIDER

BOOK

NEWS

OTHER _____