



**JOVE MEDICAL**  
 6685 Forest Hill Boulevard, Suite 201  
 West Palm Beach, FL 33413  
 Phone: (561) 432-5101  
 Fax: (561) 432-1914  
 Dr. Pedro A. Sanchez, D.O.  
 Deborah A. Collins, ARNP NP-C

**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 LOSING 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  
 BOOK  
 NEWS  
 OTHER \_\_\_\_\_