Hormone Consult Questionnaire

In addition to your medical history that has been taken as part of your medical record, please fill out the specific information related to your current medical, menstrual history and hormone symptoms. It will be helpful to make the most of your hormone consultation. If you are currently taking any prescription hormone replacement therapy, including over the counter hormone replacement creams etc, or other prescription medications, **please bring in your prescription bottles.** You do **not** need to bring in your vitamins or other supplements. Please be aware that if lab testing for hormone levels is to be done, check your insurance coverage as some lab tests can be expensive. Thank you and we look forward to seeing you soon.

Today's Date______________

Name and age___________________

Last mammogram and result________________

Last Pap smear and result__________________

Last Bone density and result_________________

Personal Medical conditions

Heart disease: Yes __ No __. List type and treatments_________________________

High cholesterol: Yes __ No __. Last lipid test_______List any medications______________

High blood pressure: Yes __ No __. List any medications_____________________

Depression: Yes __ No __. List any medications current and prior treatments/dates of treatment_________

History of blood clots in lungs or veins Yes __ No __. Date and site______________

Headaches Yes __ No __. List type, triggers, and treatments______________

History of cancer: Yes __ No __. Type, dates and treatments____________________

Have you had an abnormal pap smear: Yes __ No __. What was the diagnosis and treatment____________

Other chronic medical conditions:_________________________

Family History

Breast cancer: Yes __ No __. Family member affected__________________

Uterine cancer: Yes __ No __. Family member affected_________________

Ovarian cancer: Yes __ No __. Family member affected_________________

Heart disease: Yes __ No __. Family member affected________________

Osteoporosis: Yes __ No __. Family member affected________________

Current menstrual history

I have had a hysterectomy: Yes __ No __.

If you did have a hysterectomy, do you still have your ovaries: Yes __ No __.

Are you still having regular monthly menstrual cycles: Yes __ No __.

Are you missing menstrual cycles (i.e. having a period every 3-5 months): Yes __ No __.

Do you have menstrual cycles that last over 7 days or do you bleed more often than every 21 days:

Yes __ No __.

If you do have menstrual cycles regardless of how many a year, do you have excessive bleeding (soaking over a pad an hour): Yes __ No __.

Have you gone one full year without a period: Yes __ No __.

If you have gone one full year without a period have you had any menstrual bleeding since you stopped having menstrual cycles : Yes __ No __.

Lifestyle

Please list any supplements and any over the counter medications that you take on a daily basis including any over the counter hormone creams.

Vitamins, minerals, herbs: Yes __ No __. If yes list all_________________________

How many hours do you sleep?________________

Sleep aids: Yes __ No __. If yes list all____________________

Gastrointestinal medications such as antacids, or stool softeners: Yes __ No __. If yes list all____________________________

Do you smoke: Yes __ No __.

How often do you exercise and what type of exercise do you do?______________________

How much stress are you under and how do you manage it?__________________________

Please list all prescription medications____

Symptoms of menopause

Please rate from:	**none**	**mild**	**moderate**	**severe**
Hot flashes/sweating during the day	0	0	0	0
Hot flashes/sweating during the night				
Irritability				
Anxiety				
Mood swings				
Memory loss				
Insomnia				
Decreased libido				
Painful intercourse related to vaginal irritation or dryness				
Weight gain				
Breast tenderness				
Fatigue in the morning				
Fatigue in the afternoon				
Fatigue in the evening				
Dry skin				
Hair loss				
Increased facial or body hair				

What are the top three issues that you would like to improve:

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