Ageless Solutions

FEMALE HORMONE PATIENT QUESTIONNAIRE

Date: _____

Name: _____ Date of Birth: (_ _ / _ _ / _____)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Living With Other Number of Children? _____

Occupation: _____

Medical History

Last Menstrual Period: _____ Age At First Menstrual Period: _____

Are/Were Your Periods Usually: ☐ Regular ☐ Irregular Have Your Periods Stopped? ☐ Yes ☐ No

Have You Had A Hysterectomy? ☐ Yes ☐ No Date: _____

Are You Currently On Hormone Replacement? ☐ Yes ☐ No If So, What? _____

What Other Medications Are You Taking? _____

_____

Any Drug Allergies? _____

Do You Smoke? _____ How Many Packs Per Day? _____

Have You Had Any Surgeries And If So What? _____

Do You Have Any Of The Following Illnesses? ☐ Diabetes ☐ High Blood Pressure

☐ High Cholesterol ☐ Kidney Disease ☐ Thyroid Problems ☐ Heart Disease

☐ Heart Murmur ☐ Hepatitis/Liver Disease ☐ Osteoporosis

Have You Had A Bone Density Test And If So When? _____ Normal? ☐ Abnormal? ☐

Date Of Last Mammogram: _____ Date Of Last Pap Smear: _____

Have You Experienced Any Of The Following Symptoms Recently?

Sleep Disruption/Insomnia	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No
Short Term Memory Loss	☐ Yes	☐ No	Weight Gain	☐ Yes	☐ No
Hot Flashes	☐ Yes	☐ No	Decreased Sex Drive	☐ Yes	☐ No
Night Sweats	☐ Yes	☐ No	Harder To Reach Climax	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Vaginal Dryness	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Breast Tenderness	☐ Yes	☐ No
Irritability	☐ Yes	☐ No	Bladder Symptoms	☐ Yes	☐ No
Nervousness	☐ Yes	☐ No	Hair Loss	☐ Yes	☐ No

Family History

Any Of The Following Cancers/Illnesses In Your Family?

Uterine Cancer?	_____	Who?	_____
Ovarian Cancer?	_____	Who?	_____
Breast Cancer?	_____	Who?	_____
Colon Cancer?	_____	Who?	_____
Heart Disease?	_____	Who?	_____
Osteoporosis?	_____	Who?	_____