Female Hormone Patient Questionnaire

Date _____ Patient's Name _____ DOB _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status (circle): M D S W 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 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? (please circle)

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?_____

Personal Assessment & Stress Management

1. During the past month, what percent of the time would you say you wake up feeling fresh and fully rested?

2. The list below contains several traits that describe people. Select the answer that best describes you. Select only one response for each trait.

	Definitely not me	Somewhat like me	Much like me	Very much like me
Have a need to excel in mostly everything	☐	☐	☐	☐
Always rushed or pressed for time	☐	☐	☐	☐
Eat most meals too fast	☐	☐	☐	☐
Hard driven and competitive	☐	☐	☐	☐
Bossy and domineering	☐	☐	☐	☐

3. When you are very angry or upset about something, rate each response according to the likelihood of having the listed reaction.

	Not too likely	Somewhat likely	Very likely
Take a few breaths and talk it out	☐	☐	☐
Act like nothing is wrong or that nothing has happened	☐	☐	☐
Blame it on someone else (it's never your fault)	☐	☐	☐
Apologize even if you are right	☐	☐	☐
Take it out on someone else	☐	☐	☐
Talk it out with someone such as a friend or relative	☐	☐	☐
Get it out in the open (off your chest)	☐	☐	☐
Keep it to yourself	☐	☐	☐

4. On an average workday, how do you generally feel? If you are a homemaker, refer to your household duties; if you are unemployed, think back to your last position.
   a. Often feel inadequate or unsure of your performance ☐ Yes ☐ No
   b. Often feel "stretched to the max" with your duties ☐ Yes ☐ No
   c. Often feel pressured or very pressed for time ☐ Yes ☐ No
   d. Often times feel like work follows you home ☐ Yes ☐ No

5. In general, do you get upset if you have to wait for something? ☐ Yes ☐ No

6. How well do you feel you are able to manage stress?

   ☐ Excellent
   ☐ Good
   ☐ Average
   ☐ Fair
   ☐ Poor

7. On an average, how many hours of restful sleep do you get per night? _____
   How many hours of sleep do you think you need? _____

8. Do you take medications or alcohol to help you relax or to change your mood?

☐ Yes If so, how often? _____ ☐ No

9. From the list, select all the methods you use to relieve tension and/or stress:

☐ Read	☐ Meditate	☐ Do nothing
☐ Listen to music/play music	☐ Blow up	☐ Turn to faith/pray
☐ Smoke cigarettes/pip e	☐ Eat	☐ Take a drug
☐ Sleep	☐ Exercise or walk	☐ Go for a drive
☐ Watch television	☐ Don't think about it	☐ Call a friend/relative
☐ Cry	☐ Work/Housework	☐ Draw/paint/hobby
☐ Throw things	☐ Have an alcoholic drink	

10. Do you experience any of the following symptoms when under stress? (Select all that apply):

☐ Inability to sleep	☐ Chest pain	☐ Nervousness
☐ Upset stomach	☐ Irritability	☐ None of these symptoms
☐ Other *please explain*		

_____
_____
_____
_____
_____
_____
_____
_____

11. How close are your ties to your family and friends?

_____
_____
_____
_____
_____
_____
_____
_____

For Women

Symptom	Yes	No
Missed periods		
Pelvic or vaginal soreness or pain		
Menstrual pain		
Heavy menstrual bleeding		
Irregular periods		
Infertility		
Hot flashes/night sweats		
Under active sex drive		
Overactive sex drive		
Pre-menstrual syndrome (PMS)		
Monthly weight gain		
Bloating and swelling		
Tender breasts		
Low backache		
Vaginal itching		
Vaginal discharge or sores		
Past or present sexually transmitted disease (specify):		
Dislike of intercourse		
Pain in ovaries		
Water retention		
Craving for sweets		
Sweating throughout the day		
Vaginal dryness		
History of miscarriages		
History of ovarian cysts		
History of uterine cysts/fibroids		
History of endometriosis		
Have you had a hysterectomy? If yes, please provide the date and reason.		
Have you ever taken estrogen, progesterone, testosterone, DHEA, or hGH? If yes, which one(s) and when?		
Date of last menstrual period:		
What form of birth control do you use? Please circle. None Pill IUD Sponge Diaphragm Foam Vasectomy Condoms Tubal Ligation Hysterectomy		

Please provide the most recent date and results for the tests listed below.

Test Dates	Results
Pap smear	
Pelvic exam	
Breast exam	
Mammogram	
Colonoscopy	
Sigmoidoscopy	
Rectal exam	
Resting EKG	
Stress EKG	
Stress Echo	
Nuclear Stress	
Chest X-ray	
Eye exam/eye pressures	