Date: _____ Dr. _____ Pt. _____ #_____

CONFIDENTIAL HRT QUESTIONNAIRE SECTION 1

Place the appropriate number (0-3) next to each of the symptoms listed below.

0 = None present 1 = Mild 2 = Moderate 3 = Severe

___ Hot flashes

___ Sugar cravings

___ Water retention/Bloatedness

___ Mood swings

___ Irritability

___ High Blood Pressure • Blood pressure medication

___ Insomnia (lack of restful sleep)

___ Decreased libido (decreased sex drive)

___ Vaginal dryness

___ Swollen breasts

___ Breast tenderness

___ Fibrocystic breasts

___ Uterine fibroids (past or present)

___ Depression

___ Inability to handle stress

___ Fatigue

___ Feeling of always being cold

___ Dry, wrinkling skin

___ Headaches

___ Foggy thinking

___ Memory loss

___ Loss of concentration

___ Irregular periods

___ Monthly cramping

___ Menstrual Cycle PLEASE CHECK
__ Light periods
__ Heavy periods

___ PMS (other) PLEASE CHECK
__ Anxiety
__ Craving
__ Dizziness
__ Crying

___ Weight gain

___ Fat accumulation at hips or abdomen

___ Body aches & pains

___ Hair loss

___ Allergy - type symptoms

___ Sluggishness in the morning

___ Gallbladder problems

___ Blood sugar problems (high, low, diabetes, or hypoglycemia)

___ Blood clotting problems. Explain:_____

TOTAL: _____

OVER PLEASE

Date: _____ Dr. _____ Pt. _____ #_____

PLACE A CHECK IN THE APPROPRIATE BOX FOR EACH QUESTION. **SECTION 2**

PLEASE ANSWER EVERY QUESTION COMPLETELY. What is your current age? _____

1. Do you have osteoporosis? ☐ Yes ☐ No ☐ Unsure

2A. Have you ever had a fracture? ☐ Yes ☐ No ☐ Unsure

2B. Have you had a hysterectomy? ☐ Yes ☐ No Ovaries removed ☐ Yes ☐ No

3. What was the **first day** of your **last** menstrual period? _____

4. Are your periods regular? ☐ Yes ☐ No How many days apart? _____

5. At what age did your periods first begin? _____

6. When was your last visit to your gynecologist? _____

7. Was your exam normal? ☐ Yes ☐ No If no - list the problems _____

8. Have you ever had thyroid problems? ☐ Yes Low High ☐ No

9. Have you been told, or do you suspect that you have arthritis? ☐ Yes ☐ No

10. Have you ever had endometriosis? ☐ Yes ☐ No

11. Have you ever had a stroke (or TIA)? ☐ Yes, Date _____ ☐ No

12. Have you ever had a heart attack? ☐ Yes, Date _____ ☐ No

13. Have you ever had breast cancer? ☐ Yes, Date _____ ☐ No

14. Have you ever had uterine cancer? ☐ Yes, Date _____ ☐ No

15. Do you **currently** take birth control pills? ☐ Yes ☐ No

    If yes - list the names: _____

16. Did you **ever** take birth control pills? ☐ Yes ☐ No

    If yes - list the names: _____

17. Do you **currently** take any other hormones? ☐ Yes ☐ No

    If yes - list them: _____

18. Have you **ever** taken any other hormones? ☐ Yes ☐ No

    If yes - list them: _____

19. Do you have any auto-immune disorder? ☐ Yes ☐ No

20. Indicate what foods you **consume daily:** ☐ Meat, ☐ Milk, ☐ Soft Drinks, ☐ Coffee, ☐ Fruit, ☐ Vegetables