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Bioidentical Hormone Replacement Candidate Questionnaire

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Medical History:**

Last Menstrual Period Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hysterectomy: Yes \_\_\_\_\_\_ Complete Partial Date: \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Last Gynecologic Exam Date: \_\_\_\_\_\_\_

Last Pap Smear: Date: \_\_\_\_\_\_\_ Normal? Yes \_\_\_\_\_ No \_\_\_\_\_

 If no, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast Cancer: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Cervical/Uterine/Ovarian Cancer: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

Hormone Replacement Therapy in the past: Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional medical problems/conditions/diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History:**

Breast Cancer: No \_\_\_\_\_\_ Yes \_\_\_\_\_\_\_ Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cervical/Uterine/Ovarian Cancer: Yes \_\_\_\_\_\_ No \_\_\_\_\_\_ Who \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other cancers/medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications: Please list any medications including over the counter medicines and any vitamins, herbs, or supplements:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any surgeries:** \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list any medication allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Estrogen: Progesterone: Testosterone: Thyroid:**

\_\_ Anxiety \_\_Anxiety \_\_Fatigue \_\_Cold Hands/Feet

\_\_ Depression \_\_Agitation \_\_Depression \_\_Fatigue

\_\_ Night Sweats \_\_Breast Swelling \_\_Memory Loss \_\_Dry Skin

\_\_Hot Flashes \_\_Brest Tenderness \_\_Irritability \_\_Constipation

\_\_Dizziness \_\_Bloating \_\_Reduced Libido \_\_ Difficulty Losing Weight

\_\_Fatigue \_\_Fluid Retention \_\_Erectile Dysfunction \_\_\_Depression

\_\_Tearfulness \_\_Headaches \_\_Loss of Drive/ Competitive \_\_Memory Loss

\_\_Decreased Libido \_\_Mood Swings \_\_Longer Recovery Time \_\_Anxiety

\_\_Vaginal Dryness \_\_Sleep Disturbances \_\_Muscle Pain \_\_Muscle Aches

\_\_Vaginal Itching \_\_Heavy or Irregular Periods \_\_Joint Pain \_\_Headaches

\_\_Urinary Frequency \_\_Decreased Sense of Well-being \_\_Dry Skin

\_\_Headaches \_\_ Thinning Hair

\_\_Painful Intercourse \_\_Hoarse Voice

\_\_Dry, Flaky Skin \_\_Water Retention

\_\_Increased Wrinkles \_\_Ankle Swelling

\_\_Difficulty Sleeping \_\_Brain Fog