

Menopause and Sexual Healthcare, PC  
Bioidentical Hormone Therapy  
Medical History Questionnaire

<b>Personal data</b>		
Date	Name	
Address		
City	State	Zip
Home phone	Work phone	Cell phone
Date of birth	Age	Social Security number
<b>Referring health care provider</b>		
Name	Phone	
Address		
City	State	Zip

<b>Present symptoms</b>
<p>Please briefly describe your symptoms. Include the date of onset, any treatments prescribed and any physicians you have consulted for these symptoms.</p>
<p>What do you feel is the most important contributor to your present symptoms?</p>

Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

Past Medical History	
Please list any <b>medical problems</b> or <b>illnesses</b> you have had or have. Include any <b>hospitalizations</b> and <b>accidents</b> . Please include the approximate date of the event or diagnosis.	
Date	Medical diagnosis, illness, accident

Please list any <b>surgeries</b> you have had.	
Date	Surgery

Please report any past or present <b>radiation therapy</b> or <b>chemotherapy</b> .				
start		stop		
mo	yr	mo	yr	



Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

<b>Family history</b>		
Please fill in this chart to the best of your ability. Include such illnesses as heart disease, stroke, diabetes, high blood pressure, neurologic disease, mental health disorders, etc. If family member is deceased, list age at death and cause of death if known.		
Relation	Age	Medical problems/cause of death
Mother		
Father		
brothers		
sisters		
children		
spouse		
<b>Lifestyle questions</b>		
<p>Do you work outside your home? Yes _____ no _____</p> <p>If yes, what is your current occupation?</p> <p>Are you currently in a relationship(s)? Yes _____ no _____</p> <p>If yes, are you involved with a man, woman or both? _____</p> <p>Do you exercise? Yes _____ no _____</p> <p>If yes, what is your usual routine?</p> <p>Do you feel safe at home? _____</p> <p>Please list specific stressors in your life:</p>		

Menopause and Sexual Healthcare, PC  
Bioidentical Hormone Therapy  
Medical History Questionnaire

**Social habits.**

Please remember this information is strictly confidentially and will be used only to address your symptom complaints.

Do you smoke **cigarettes** now or have you in the past? Yes \_\_\_ No \_\_\_

If yes, how many packs per day? \_\_\_\_\_

How many years total have you smoked? \_\_\_\_\_

Do you drink **alcohol**? Yes \_\_\_ No \_\_\_

If yes, how many drinks of any kind do you have in an average week? \_\_\_\_\_

Have you ever had a legal consequence to drinking alcohol? \_\_\_\_\_

Do you now or have you in the past used any **illicit drugs** (marijuana, amphetamines, narcotics, psychedelics, cocaine) yes \_\_\_ no \_\_\_

**Mental health history.**

Have you ever been diagnosed or treated for depression? Yes \_\_\_ no \_\_\_

If yes, please estimate dates of treatment: \_\_\_\_\_

Have you been hospitalized for depression or other mental difficulties?

Have you ever attempted suicide? Yes \_\_\_ No \_\_\_

Do you currently have thoughts of suicide? Yes \_\_\_ no \_\_\_

Do you suffer from anxiety? Yes \_\_\_ no \_\_\_

Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

<b>Gynecologic history</b>		
Date of last PAP smear? _____		
Physician who performed? _____		
Phone Number: _____		
Date of last mammogram? _____		
Facility Name: _____		
Phone Number: _____		
When was your last Bone Density Test? _____		
	YES	NO
Have you had breast biopsies in the past?		
Have you noticed skin or nipple changes?		
Have you noticed any lumps in your breasts?		
Do you have breast pain?		
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have?		
Are you using a birth control method? If yes, what kind? _____		

Menopause and Sexual Healthcare, PC  
Bioidentical Hormone Therapy  
Medical History Questionnaire

**Childbirth history**

Total # of pregnancies \_\_\_\_\_ #of live births \_\_\_\_\_

# of abortions or miscarriages \_\_\_\_\_ #of premature deliveries \_\_\_\_\_

# of children still living \_\_\_\_\_

At what ages were you pregnant? \_\_\_\_\_

How many vaginal deliveries have you had? \_\_\_\_\_

How many C-sections have you had? \_\_\_\_\_

Have you had any multiple births (twins, triplets, etc.)? \_\_\_\_\_

Have you had any prolonged or difficult births? If yes, please describe what happened.

**Menstrual history**

Are you still having menstrual periods?

If yes, when was the first day of your last period?

Please describe any problems, if any, you have with your periods.

Periods are (were) \_\_regular \_\_irregular \_\_painful \_\_crampy \_\_heavy \_\_light

Age periods began: \_\_\_\_\_ # days of bleeding \_\_\_\_\_ cycle length \_\_\_\_\_

If you are no longer having periods, at what age did your periods stop?

If your periods stopped less than one year ago, how many months ago was your last period?

Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

Did your periods stop because you had a hysterectomy?

If yes, please answer the following questions:

What was the reason for the surgery?

Was the uterus removed through the vagina or through an incision in the abdomen?

Were the ovaries removed at the same time?

**Hormone therapy history**

Have you been treated with any hormone replacement therapy?

If yes, please give approximate periods of treatment:

Hormone used and dose if known	reason	start date	stop date

Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

**Check which of these symptoms are troublesome and persist over time.**

<b>Estrogen Deficiency</b>	<b>Estrogen Excess Progesterone Deficiency</b>	
___ Hot Flashes	___ Mood Swings (PMS)	___ Cystic Ovaries
___ Night Sweats	___ Tender Breasts	___ Heavy Menses
___ Vaginal Dryness	___ Water Retention	___ Breast Cancer
___ Foggy Thinking	___ Nervous	___ Sleep Disturbance
___ Memory Lapses	___ Irritable	___ Sugar Craving
___ Incontinence	___ Anxious	___ Elevated Triglycerides
___ Tearful	___ Fibrocystic Breasts	___ Weight Gain - Waist
___ Depressed	___ Uterine Fibroids	___ Low Libido
___ Sleep Disturbances	___ Weight Gain - Hips	
___ Heart Palpitations	___ Bleeding Changes	
___ Bone Loss	___ Headaches	
___ Headaches	___ Cold Body Temperature	

**Check which of these symptoms are troublesome and persist over time.**

<b>Androgen Excess</b>	<b>Androgen Deficiency</b>	
___ Increased Facial Hair	___ Low Libido	___ Heart Palpitations
___ Increased Body Hair	___ Vaginal Dryness	___ Headaches
___ Loss of Scalp Hair	___ Fatigue	___ Fibromyalgia
___ Acne	___ Aches/Pains	___ Irritable
___ Oily Skin	___ Memory Lapses	___ Thinning Skin
___ Nervous	___ Foggy Thinking	
___ Irritable	___ Incontinence	
___ Anxious	___ Depressed	
___ Ovarian Cysts	___ Sleep Disturbances	
___ Elevated Triglycerides	___ Bone Loss	
___ Sleep Disturbances	___ Decreased Muscle Mass	
___ Breast Cancer		

**Check which of these symptoms are troublesome and persist over time.**

<b>Cortisol Excess</b>		<b>Cortisol Deficiency</b>
___ Sleep Disturbances	___ Heart Palpitations	___ Fatigue
___ Bone Loss	___ Headaches	___ Sugar Craving
___ Fatigue	___ Stress	___ Allergies
___ Weight Gain - Waist	___ Cold Body Temperature	___ Chemical Sensitivity
___ Loss of Muscle Mass	___ Sugar Cravings	___ Stress
___ Thinning Skin	___ Low Libido	___ Cold Body Temp.
___ Elevated Triglycerides	___ Hair Loss	___ Irritable
___ Breast Cancer	___ Increased Facial Hair	___ Arthritis
___ Irritable	___ Increased Body Hair	___ Heart Palpitations
___ Anxious	___ Acne	___ Aches/Pains
___ Memory Lapse	___ Nervous	

Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

<b>System review.</b> Please check the appropriate box for each question.			
	YES	NO	Don't know
<b>CONSTITUTIONAL/ID/ONCOLOGY</b>			
Have you had unexplained weight loss?			
Do you have fever or chills?			
Do you have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive for HIV?			
Have you ever had a sexually transmitted disease?			
<b>RESPIRATORY</b>			
Do you have a cough?			
Do you wheeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with any lung diseases such as asthma or emphysema?			
<b>CARDIOVASCULAR</b>			
Do you have chest pain?			
Do you have palpitations?			
Do you have shortness of breath?			
Do you have swelling in your legs?			
Do you have leg pain while walking?			
Have you been diagnosed with any heart conditions?			
Have you ever had a blood clot?			
<b>GASTROINTESTINAL</b>			
Do you have trouble swallowing food?			
Do you have nausea or vomiting?			
Do you have diarrhea?			
Do you have blood in your stool?			
Do you have abdominal pain or swelling?			
Have you ever been diagnosed with hepatitis or other liver diseases?			

Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

	YES	NO	Don't know
<b>ENDOCRINE</b>			
Do you have intolerance to heat?			
Do you have intolerance to cold?			
Has your voice become hoarse?			
Do you have constipation?			
Do you feel fatigued?			
Do you urinate in larger amounts than usual?			
Do you have a greater than normal urge to eat?			
Are you excessively thirsty?			
Do you have facial hair?			
Do you have acne currently?			
Have you gained weight around your waist?			
Have you gained weight around your hips?			
Have you ever been diagnosed with a goiter or thyroid problems?			
<b>NEUROLOGIC</b>			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you ever had a transient loss of speech or vision?			
Do you experience double vision or blind spots?			
Have you ever been diagnosed with a stroke or transient ischemic attack?			
<b>UROLOGIC/RENAL</b>			
Do you have burning when you urinate?			
Do you have urgency to urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing, or exercising?			
Do you have trouble holding your urine until reaching the bathroom?			
Do you get up frequently during the night to urinate?			
Have you ever had any kidney problems?			

Menopause and Sexual Healthcare, PC  
 Bioidentical Hormone Therapy  
 Medical History Questionnaire

	YES	NO	Don't know
<b>GYNECOLOGIC</b>			
Please check if you have had any of the following:			
- Premenstrual syndrome			
- Uterine fibroid tumors			
- Menopausal bleeding			
- Ovarian cysts			
- Endometriosis			
- Gynecologic surgery _____			
Cancer of:			
- Vulva			
- Vagina			
- Cervix			
- Uterus			
- Ovary			
- Fallopian tube			
- Breast			
- Colon			
- Other _____			