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Female Hormone Symptom Questionnaire

Patient Name_____Date_____

Please describe your main problem or concerns:

Have you ever taken hormone replacement in the past (synthetic or bio-identical)? Please describe if this helped you or if you had any adverse reactions.

What medications, supplements, and vitamins are you taking currently?

Date of Last Menstrual Period:_____

Date of Last PAP smear: _____Any prior abnormal PAP smears?_____

Date of Last Mammogram:_____Any prior abnormal mammograms?_____

Any prior breast biopsies?_____Any prior breast surgeries?_____

Any personal or family history of breast lumps, breast cancer, endometrial (uterine) cancer, heart disease, stroke, or blood clots? If yes, please provide details.

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Please check the status of any symptoms you are experiencing:

Symptom	**None**	**Mild**	**Moderate**	**Severe**
Hot flashes				
Weight gain				
Difficulty concentrating				
Problems with memory				
Breast tenderness				
Breast lumps				
Difficulty falling asleep				
Difficulty staying asleep				
Decreased libido (sex drive, or desire)				
Vaginal dryness				
Pain with intercourse				
Bladder incontinence				
Irregular vaginal bleeding or spotting				
Fatigue				
Anxiety				
Depression				
Mood swings				
Dry skin / hair				
Hair loss				
Headaches				