

Bon Sain
Complete Women's Healthcare
Hormone Replacement Questionnaire

Name _____ Date of birth _____

Primary Care Physician _____

Menopause Y/N _____ Last Menstrual Period _____

Pregnancies: Term _____ Premature _____ Miscarriages _____ Living _____

Height _____ Weight _____

Please **select** and **number** in order of importance to you, your **top three symptoms:**

- | | | |
|---|---|--|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Abnormal Hair |
| <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Cloudy Thinking | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Moodiness | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Low Stamina |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Low Libido |
| <input type="checkbox"/> Crying Spells | <input type="checkbox"/> Constipation | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Dry Vagina |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Acne | <input type="checkbox"/> Irritated Vulva |
| <input type="checkbox"/> Irregular or Heavy Periods | | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Just Don't Feel "Right" | <input type="checkbox"/> Other _____ | |
-

Please mark any other symptoms you may be experiencing:

- | | | |
|---|---|--|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Abnormal Hair |
| <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Cloudy Thinking | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Moodiness | <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Low Stamina |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Low Libido(Sex Drive) |
| <input type="checkbox"/> Crying Spells | <input type="checkbox"/> Constipation | <input type="checkbox"/> Painful Intercourse |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Dry Vagina |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Acne | <input type="checkbox"/> Irritated Vulva |
| <input type="checkbox"/> Irregular or Heavy Periods | <input type="checkbox"/> PMS | |
| <input type="checkbox"/> Just Don't Feel "Right" | <input type="checkbox"/> Other _____ | |

Please describe how you sleep.

Hours of sleep/night____ Bedtime__:_PM Awaken at __:_AM

Do you awaken during the night ? Y/N ____ # times _____

Do you have trouble getting to sleep ? Y/N____

Are you awakened with hot flashes or night sweats ?Y/N _____

Do you get up to urinate ? Y/N_____ # times _____

Do you use sleep aide medications (Rx or over the counter)? Y/N____ list _____, _____, _____

Contraceptive Use (Ever): Never Y/N__, Birth Control Pill Y/N____

IUD Y/N____, DepoProvera Y/N____, Norplant Y/N____, Tubal Ligation Y/N____

Menstrual History: (Even if you are menopausal)

Age at 1st menstrual period _____ frequency of cycles _____ days

Regular or Irregular ? _____ Last Menstrual Period _____(approx.)

Usual Length of Bleeding _____days PMS Y/N _____

Have you ever been on hormone replacement therapy ? Y/N _____

If so, please list:

Medication & Date	Response	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History: (Please list all medical conditions such as Hypertension, Diabetes, High Cholesterol, etc.)

List All Current Medications & Supplements:

Drug Allergies: _____

List All Surgeries: Procedure Date

_____	_____
_____	_____
_____	_____
_____	_____

Family History: Have any immediate family members had Breast or Ovarian Cancer? Y/N_____
Relationship _____

Mother's Health Issues _____

Father's Health Issues _____

Sibling's Health Issues _____

Screening/Preventive Health:

Last Pap _____ Result _____

Last Mammogram _____ Result _____

Last Colonoscopy _____ Result _____

Last Bone Density _____ Result _____

Pneumonia Vaccination _____

Hepatitis Vaccination _____

Tetanus Booster _____

Influenza Vaccination _____