Women's Hormone Questionnaire

Please answer the following questions to the best of your ability. Your answers will help me help you. This is a confidential questionnaire and will not be a part of your medical record.

Print Name_____ Date of Birth_____

Are you here for hormone balance?

YES ___ NO___ If yes please complete this form, if no, please give a brief description of why you are here today:

_____

Do you currently, or have you ever, taken hormone replacement? YES ___ NO ___

If yes, please describe what you have taken and if it helped with your symptoms:

_____

In order of importance, please list the three symptoms you would like to address the most:

1. _____
2. _____
3. _____

Have you done anything to alleviate these symptoms? _____

How long have you been feeling the way you are today? _____

When was the last time you felt like yourself? _____

# of Pregnancies: _____ Complications: _____

PLEASE RATE YOUR SYMPTOMS from 1-5 (1 being the least, 5 being the most)

Angry: _____ Anxious: _____ Decreased Libido: _____ Depressed: _____ Difficulty concentrating: _____

Dry Skin: _____ Fatigue: _____ Hair Loss: _____ Headaches: _____ Hot Flashes: _____ Irritability: _____

Memory Concerns: _____ Mood Swings: _____ Night Sweats: _____ Not feeling like yourself: _____

Pain w/intercourse: _____ Pelvic Pain: _____ Sleep Disturbance: ____ Tearful: ____ Urinary Concerns: ____

Vaginal Dryness: _____ Weight Gain: _____ Other: _____

Please describe any other symptoms/concerns even if they sound silly to you, include anything else you feel would be helpful for me to know:_____

_____

The DEA has classified testosterone as a CSA class III drug. Patients receiving any type of class III drug are required by state regulations to be seen by their provider, at a minimum of every **five months**. If you are receiving testosterone as part of your BHRT therapy, it is your responsibility to be seen in the office to be determined by your plan of care and prescription, in order to have your prescription renewed. These visits must be an in office or Telehealth visit.

_____ _____

Patient Signature **Date**