

## Female Bioidentical Hormone Replacement Questionnaire

<b>Personal Data</b>			
Name	Date		
Address	City	State	Zip
Home phone	Work phone	Cell phone	
Date of birth	Age		
Email	How did you hear about us		
Emergency Contact	Relationship	Telephone	
<b>Primary Care Physician</b>			
Name	Phone		
Address	City	State	Zip
<b>Present Symptoms</b>			
Please briefly describe your symptoms.			
What do you feel is the most important factor to your present symptoms?			

**Past Medical History**

Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.

Date	Medical diagnosis, illness, accident

**Past Surgical History**

Date	Surgery

**Medications**

Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**

Name of Medication	Dosage	Dosing schedule

**Allergies**

Are you allergic to ANY MEDICATIONS (prescription or over the counter).


### Family History

Please list ALL illness (heart disease, stroke, diabetes, hypertension, cancer (breast, cervical, prostate, lung, skin, blood), etc. If a member is deceased, please list age at death and cause of death if known.

Relationship	Age	Medical problem / Cause of death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

### Social History

Please remember this information is strictly confidential and will be used only to address you symptoms and/or complaints.

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

- If yes, how many packs per day? \_\_\_\_\_
- How many total years have you smoked? \_\_\_\_\_

Do you drink alcohol?     Yes     No

- If yes, how many drinks and what kind (wine, beer, bourbon, etc.) do you have in an average week? \_\_\_\_\_.

Do you now or have you in the past used any illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)?     Yes     No

- If yes, what substance and how often \_\_\_\_\_.

## Gynecological History

Date of last PAP smear? \_\_\_\_\_ Physician who performed? \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_.

Date of last mammogram? \_\_\_\_\_ Facility where performed: \_\_\_\_\_

Facility Phone Number: \_\_\_\_\_.

	YES	NO
Have you ever had an abnormal PAP smear? If yes, what was the abnormality and what follow up did you have? _____		
Have you ever had an abnormal mammogram? If yes, what was the abnormality and what follow up did you have? _____		
Have you ever had a breast biopsy?		
Have you ever had a cervical biopsy?		
Have you noticed breast skin or nipple changes?		
Have you noticed any lumps in your breasts?		
Are you using a birth control method? If yes, what kind?		
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) <input type="checkbox"/> regular <input type="checkbox"/> irregular <input type="checkbox"/> painful <input type="checkbox"/> crampy <input type="checkbox"/> heavy <input type="checkbox"/> light		
Age periods began: _____ # days of bleeding _____ cycle length _____		
If you are no longer having periods, at what age did you periods stop? _____		
If your periods stopped less than one year ago, how many months ago was your last period? _____		
Did your periods stop because you had a hysterectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<ul style="list-style-type: none"> <li>• If yes what was the reason for the surgery? _____</li> <li>• Were the ovaries removed at the same time? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure</li> </ul>		
Do you have a history of any of the following <b>cancers</b> :		
<input type="checkbox"/> Vulva <input type="checkbox"/> Uterus <input type="checkbox"/> Vagina <input type="checkbox"/> Cervix	<input type="checkbox"/> Ovary <input type="checkbox"/> Fallopian Tube <input type="checkbox"/> Breast <input type="checkbox"/> Colon	<input type="checkbox"/> Other:

## Hormone Therapy History

Have you been treated with any hormone replacement therapy? If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

## Estrogens

Check which of these symptoms are troublesome and have persisted over time

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

## Androgens

Check which of these symptoms are troublesome and have persisted over time

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

## Adrenals

Check which of these symptoms are troublesome and have persisted over time

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

## Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess	Thyroid Deficiency
<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Cold Intolerance
<input type="checkbox"/> Voice has become horse	<input type="checkbox"/> Constipation
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Fatigued / Weakness
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Unexplained Weight Gain
<input type="checkbox"/> Tremors / Shakiness	<input type="checkbox"/> Inability to Loose Weight
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Stress
<input type="checkbox"/> Nervousness / Anxious / Panic Attacks	<input type="checkbox"/> Cold Body Temperature
<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Irritable
<input type="checkbox"/> Difficulty Conceiving / Infertility	<input type="checkbox"/> Lack of Motivation
<input type="checkbox"/> Coarse Dry Skin	<input type="checkbox"/> Muscle Cramps
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Aches/Pains

## System Review – Check the appropriate box for each question.

Constitutional / ID / Oncology	Yes	No	Not Sure
Have you had unexplained weight loss?			
Do you have fever or chills?			
Do have night sweats?			
Do you notice swollen lymph nodes?			
Have you ever been diagnosed with cancer?			
Have you ever tested positive of HIV?			
Have you ever had a sexually transmitted disease?			
<b>Respiratory</b>			
Do you have a cough?			
Do you frequently sneeze?			
Do you have excessive daytime sleepiness?			
Do you snore?			
Have you ever been diagnosed with asthma or emphysema			

**System Review – Check the appropriate box for each question.**

<b>Cardiovascular</b>	<b>Yes</b>	<b>No</b>	<b>Not Sure</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 diagnoses with any heart condition?			
Have you ever been diagnosed with 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 diagnoses with hepatitis or liver disease?			
<b>Endocrine</b>			
Do you urinate frequently or 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?			
Have you ever been diagnosed with a thyroid problem?			
<b>Neurological</b>			
Do you have muscle weakness?			
Have you ever had a seizure?			
Have you ever fainted?			
Have you experienced double vision or blind spots?			
Have you ever been diagnosed with a stroke?			
<b>Urologic / Renal</b>			
Do you have burning when you urinate?			
Do you have urgency when you urinate?			
Do you urinate more frequently than others?			
Do you leak urine when laughing or coughing?			
Have you ever had any kidney problems?			

Physician Notes:

## Disclosure / Liability Waiver

Bay Area Aesthetics & Wellness – Bioidentical Hormone Replacement Program and its providers follow guidelines set forth by the FDA and National Institutes of Health. While numerous safety measures are taken by our physicians and staff, incidental events may occur that is beyond the control of our staff. Within the medical community, there are opposing views with respect to the use of bioidentical hormonal replacement therapies. The Women’s Health Initiative (WHI) exposed many of the benefits and risks of traditional hormonal replacement therapies. The WHI publication can be found at the following internet address:

<http://www.nlm.nih.gov/medlineplus/hormonereplacementtherapy>. The use of bioidentical hormones does provide true medical benefit, and is being used at our center to lessen/treat non-life threatening symptoms you have identified as bothersome, undesirable, and frankly unwanted. It is therefore expressly agreed that you are voluntarily participating in this program and all bioidentical hormonal replacement regimens, and the use of any medications and/or supplements is undertaken at your own risk. You are voluntarily participating in this program and assume all the risks of injury to yourself that might result. You hereby agree to waive any claims or rights you might otherwise have to pursue legal remedies from Bay Area Aesthetics & Wellness, its staff, or treating providers for injury to you on account of involvement in the Bioidentical Hormone Replacement Program. You have carefully read this waiver and fully understand that it is a release of liability.

I accept all terms and conditions of this offer.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

## Maintenance of Preventative Medicine and Cancer Surveillance

A requirement for acceptance and continuation in the bioidentical hormone replacement program is the documentation of routine cancer screening (within 3 months of beginning the program). You must provide documentation showing the results of a breast exam, mammogram (if high risk or over age 40) and gynecological exam (including PAP smear). If these requirements are not met, we will provide them for an additional charge, or will have to terminate your participation in the program.

I accept all terms and conditions of this offer.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date