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Bio-identical Hormone Replacement Therapy Questionnaire

Name:_____ Age:_____ Phone number:_____

Hormone Therapy History:
Are you currently or have had hormone replacement therapy? ____ Yes ____ No
If yes, what type of hormones have you had replaced or balanced?
_____ Estrogen
_____ Thyroid
_____ Cortisol
_____ Progesterone
_____ Testosterone

Present Symptoms:
As you have aged, have you experienced any of the following?
_____ Decreased muscle mass/increased muscle stiffness
_____ Reduced strength
_____ Significant weight loss or gain
_____ Fluctuations in body temperature
_____ Night sweats/sleep difficulties
_____ Increased anger/irritability
_____ Forgetfulness
_____ Alcohol intolerance
_____ Poor sleep/insomnia
_____ Sensitivity to heat/cold
_____ Mood swings/changes
_____ Dryer or thinning skin and hair
_____ Depression/anxiety

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

Hormones- Women:

_____ Hot flashes
_____ Urinary incontinence/urgency
_____ Painful intercourse/vaginal dryness
_____ Frequent drowsiness/ fatigue
_____ Decreased bone density
_____ Night sweats/sleep disturbances
_____ Irritability/mood changes
_____ Weight gain
_____ Anxiety/depression
_____ Thinning hair
_____ Aches/pains
_____ Foggy thinking
_____Decreased height
_____Decreased libido
_____ Irregular periods
_____ Skin dryness

Hormones- Men:

Date of last prostate exam: _____ Date of last PSA test: _____

_____ Decreased sex drive/libido
_____ Decreased energy/fatigue
_____ Anxiety/depression
_____ Weight gain
_____ Aches/pains
_____Frequent drowsiness
_____Decreased mental sharpness/foggy thinking
_____ Irritability/mood changes
_____ Night sweats/sleep disturbances
_____Loss of muscle mass
_____Hair loss/thinning
_____Prostate enlargement
_____Decreased height