Women's Hormone Therapy History Form

Date _____

Patient Name _____Date of Birth _____ Phone _____

Address _____ Email _____

Any History of blood clots or heart disease _____ Sexually Active? Yes / No

CURRENT DATE:

Bone Density Scan _____ Results _____

Pap Smear _____ Results _____

Mammogram _____ Results _____

Hysterectomy: complete/partial _____ Cancer History _____

Menstrual/cycle history _____ Days/number of heavy days _____

Abnormal Bleeding: _____ **Cramps:** Severe/ Moderate/ Mild **PMS:** Severe/ Moderate/ Mild

GYN _____ Primary Care Physician _____

Hormone Replacement Therapy – Review Dose Current _____

Previous _____

Problems Associated with present dose _____

CIRCLE WHICH SYMPTOMS YOU ARE EXPERIENCING AT PRESENT:

Energy (Good | Fair| Poor)	Cravings
Appetite (Good | Fair | Poor)	Breast Tenderness
Sleep (Good | Fair | Poor)	Vaginal Dryness
Libido (sex drive) Decreased / Increased	Painful Intercourse
Joint Complaints	Fibrocystic Breasts
Night Sweats/Hot Flashes	Fuzzy Thinking
Mood Changes/Depression / Anxiety/ Irritability	Hair Loss
Bloating	Bladder/Yeast Infection
Bleeding (Vaginal)	Urinary Incontinence/Urgency

Medications (Prescriptions and Supplements) _____

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