Hormone Replacement Therapy Medical History – Female

Date: ____/____/_____

Name: ____ Date of Birth: _____________________

Address: ____

City: _________________________________ State: _____________ Zip Code: _____________

Phone: (Home) _____________________________ (Cell) ________________________________

Primary Care Physician: ____

I. Past Medical History:

High Blood Pressure	Yes	○	No	○
Heart Disease:	Yes	○	No	○
High Cholesterol:	Yes	○	No	○
Diabetes:	Yes	○	No	○
Stroke	Yes	○	No	○
Blood clots of Clotting Disorders:	Yes	○	No	○
Bleeding Disorders:	Yes	○	No	○
Depression / Anxiety:	Yes	○	No	○
Fibroids:	Yes	○	No	○
Thyroid Problems:	Yes	○	No	○
Migraines:	Yes	○	No	○
Hepatitis or Liver Disease:	Yes	○	No	○
Rheumatoid Arthritis:	Yes	○	No	○
Bone Loss (Osteopenia or Osteoporosis):	Yes	○	No	○
Cancer:	Yes	○	No	○
Kidney Disease:	Yes	○	No	○
Immune Disorder:	Yes	○	No	○

Please list any additional medical history in the space below:

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II. Past Surgical History:

1. ________________________ Date of Surgery: _____________
2. ________________________ Date of Surgery: _____________
3. ________________________ Date of Surgery: _____________
4. ________________________ Date of Surgery: _____________
5. ________________________ Date of Surgery: _____________

III. Current Medications (Prescribed and OTC), dose and frequency:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________

IV. Allergies: (medication, food, etc…)

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

V. Gynecological History:

1. What is the date of your last menstrual period? _________________
2. How old were you when you got your first period? _______________
3. Have you ever used birth control pills? ______For how long? ______
4. Were you ever told NOT to use birth control? ___________________
5. If you are still having periods, have you noticed a change in the following:
   - Frequency of periods
   - Amount of flow
   - Duration of periods
   - Discomfort with periods
   - Physical or emotional changes
   - Bleeding between periods
6. Are you sexually active? _________________
7. If you are still menstruating, what form of contraception are you using? _________________
8. Have you had a hysterectomy? _________ If yes, when? ____________
9. Were your ovaries removed? ____________
10. Have you ever taken Hormone Replacement Therapy?____ If so, when? _____
11. Any reaction to HRT (ex. Bloating, headache/migraine, blood pressure rise, nausea, or depression)? If yes, please explain: ______________________________

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12. What form of estrogen did you use: ______ pills ______patch ______cream

VI. Social History

Occupation: ______________________ **Ethnic Background:** _________________

Diet: Regular ___ Vegetarian ____ Diabetic ____ Lo w Carb ____ Other __________

Hours Exercise per Week: 1 – 2 2 – 3 3 – 4 4 – 5 > 5

What Types? ____

Have you ever broken any bones? Yes ___ No ___ If yes, explain: _____________

Do you smoke? Yes ____ No ____ If yes, how much? _______________________

Do you drink alcohol? Yes ____ No ____ if yes, how much? __________________

VII: Family History:

Illness	**Relationship**
○ Heart Disease:	____________________________________
○ Breast Cancer	____________________________________
○ Ovarian Cancer	____________________________________
○ Uterine Cancer	____________________________________
○ Colon Cancer	____________________________________
○ Malignant Melanoma	____________________________________
○ Osteoporosis	____________________________________
○ Diabetes	____________________________________
○ Alzheimer’s Disease	____________________________________

VIII: Symptoms

Forgetfulness:	Yes	○	No	○
Inability to Concentrate:	Yes	○	No	○
Memory Loss:	Yes	○	No	○
Depression:	Yes	○	No	○
Heart Palpitations:	Yes	○	No	○
Irritability:	Yes	○	No	○
Insomnia:	Yes	○	No	○
Panic Attacks:	Yes	○	No	○
Worry Needlessly:	Yes	○	No	○
Height Loss:	Yes	○	No	○
Fatigue:	Yes	○	No	○

Joint Pain:	Yes	○	No	○
Excess hair Growth:	Yes	○	No	○
Burning with Urination:	Yes	○	No	○
Urine Leakage:	Yes	○	No	○
Irritable Bowel:	Yes	○	No	○
Decreased Sex Drive:	Yes	○	No	○
Painful Intercourse:	Yes	○	No	○
Vaginal Dryness:	Yes	○	No	○
Dry Eyes:	Yes	○	No	○
Dry Skin:	Yes	○	No	○
Hot Flashes/Night Sweats:	Yes	○	No	○
Breast Pain:	Yes	○	No	○
Cold Hands/Feet:	Yes	○	No	○
Mood Swings:	Yes	○	No	○
Hair Loss/Thinning:	Yes	○	No	○
Weight Gain:	Yes	○	No	○
Loss of interest:	Yes	○	No	○