

PATIENT QUESTIONNAIRE TO BEGIN HORMONE THERAPY

Name: _____ Date: _____

Age: _____ Date of Last Period: _____

Please circle the symptoms that are true for you:

1. I have hot flashes and night sweats that impair my sleep.
2. I have developed dry eyes.
3. I have migraines that have gotten worse since my 30's.
4. I have PMS.
5. I am depressed.
6. I am anxious.
7. I am more irritable than I was a few years ago.
8. I do not enjoy life anymore.
9. I have gained weight since my symptoms started.
10. My strength has decreased as well as my exercise tolerance.
11. I have developed cellulite and poor skin tone.
12. I have a new onset of wrinkles and drooping skin.
13. I have no energy.
14. My sex drive is gone.
15. My husband/partner and I are not getting along.
16. I feel hopeless.
17. I cannot think clearly anymore.
18. My memory for names is gone.
19. I don't sleep through the night and have no energy during the day.

Past Medical History (please circle):

Breast Cancer Uterine Cancer Ovarian Cancer
Myocardial Infarction Life Threatening Blood Clots
Other _____

Allergies to Drugs: _____

Medications: _____

Family History (please circle):

Breast Cancer Uterine Cancer Ovarian Cancer
Myocardial Infarction Life Threatening Blood Clots
Other _____

Patient Signature