Hormone Health History Questionnaire

Name:____ **DOB:**__________________

Previous or referring doctor:____

List your current prescribed medications and over the counter drugs

(Or attach current medication list)

Name of Medication	Dose	Frequency Taken

ALLERGIES TO MEDICATIONS:

Name the Drug	Reaction you had

SURGERIES:

Year	Type of Surgery	Hospital

TESTS:

	Where	Year
MRI		
CT Scan		
EMG/NCV		
X-RAYS		
EEG		
Blood work		

PERSONAL HEALTH HISTORY:

Do you have or have you had any of the following:

Heart Disease	Liver Disease	Seizures	Migraines
High Blood Pressure	Lung Disease	HIV/AIDS	Cancer
Diabetes	Stroke	Depression	
GI Disorders	Blood Disorders	Hepatitis	
Thyroid Problems	High Cholesterol	Fibromyalgia	

Other: ____

SOCIAL HISTORY:

Marital Status:			Single Divorced Married Separated Widowed
Do you have any children?			Yes No If so, how many: _____________
Tobacco (Smoking/Chewing):			Current Smoker Former Smoker Never Smoked
Illicit Drugs:	Yes	No	If so, describe:________________________________
Caffeine:	Yes	No	If so, how many cups a day: ____________________
Exercise:	Yes	No	3-5 times a week Daily Mild None

FAMILY HISTORY

****Please list any medical conditions your immediate family members have been diagnosed with****

Heart Problems:	Yes	No	If so, who: ___________________________________
High Blood Pressure:	Yes	No	If so, who: ___________________________________
Kidney Problems:	Yes	No	If so, who: ___________________________________
Diabetes:	Yes	No	If so, who: ___________________________________
Liver Problems:	Yes	No	If so, who: ___________________________________
Cancer:	Yes	No	If so, who and what kind: _______________________
Lung Disease/Asthma:	Yes	No	If so, who: ___________________________________
GI/Stomach Problems:	Yes	No	If so, who: ___________________________________
Migraine/Headaches:	Yes	No	If so, who: ___________________________________

Bleeding or Blood Disorder: Yes No If so, who: ________________________________
Anxiety or Depression: Yes No If so, who: ________________________________
Tremor: Yes No If so, who: ________________________________
Stroke: Yes No If so, who: ________________________________
Multiple Sclerosis: Yes No If so, who: ________________________________
Parkinson's disease: Yes No If so, who: ________________________________
Psychiatric Illness: Yes No If so, who: ________________________________
High Cholesterol: Yes No If so, who:________________________________
Other: ____

WOMEN ONLY

Age at onset of menstruation: ____________________________
First day of your last period: ____________________________
Period every ____ days
Heavy periods, irregularity, spotting, pain, or discharge? Yes No
Number of pregnancies ______ Number of live births _______
Are you pregnant or breastfeeding? Yes No
Any urinary tract, bladder, or kidney infections with in the last year? Yes No
Any blood in your urine? Yes No
Any problems with control of urination? Yes No
Any hot flashes or night sweats? Yes No
Experienced any recent breast tenderness, lumps or nipple discharge? Yes No

MEN ONLY

Do you get up to urinate during the night? Yes No

Do you have pain or burning with urination? Yes No

Any blood in your urine? Yes No

Has the force of urination decreased? Yes No

Have you had any kidney/ bladder/prostate problems? Yes No

Any problems emptying your bladder completely? Yes No

Any difficulty with erection or ejaculation? Yes No

Any testicle pain or swelling? Yes No

SYMPTOMS

Please rate the following symptoms:

0= Rarely a problem **1=** Mild **2=** Moderate **3=** This is serious for me

___ Constipation
___ Difficulty sleeping
___ Joint pains
___ Moodiness
___ Headaches/Migraines
___ Foggy Thinking
___ Breast Tenderness
___ Sugar or food cravings
___ Feeling of depression
___ Body pain
___ Dry hair or skin
___ Loss of Motivation
___ Difficulty concentrating
___ Hair loss
___ Oily Skin
___ Unable to reach orgasm
___ Irritability
___ Increase in waist size
___ Inability to ejaculate
___ Memory loss
___ Back Aches
___ Anxiety
___ Weight gain
___ Weight loss
___ Increased body/facial hair
___ Fatigue
___ Inability to lose weight
___ Can't maintain an erection
___ Acne
___ Low Libido

Other: ____
____