FEMALE HORMONE QUESTIONAIRE

- Menopause is defined as the end of menstruation. The term is commonly used to refer to the period indicating the end of the female reproductive phase of life. True menopause is when a woman has stopped menstruating for one year or longer.
- When a woman's cycle begins to lengthen, or when she skips a period there is a good chance she is nearing menopause. When a woman's cycle is shortening and her periods are more frequent that is a sign NOT of menopause but of adrenal exhaustion.
- As the years of menopause pass, the risk of serious cardiovascular disease, high blood pressure, heart attack and stroke rise dramatically.
  Cardiovascular disease is the leading cause of death in post-menopausal women surpassing even cancer.
- The danger of osteoporosis increases after menopause, increasing the risk for hip fractures, as well as wrist, hip and spine.
- The largest percentage of bone density is lost in the first two years of menopause.

All women who are entering menopause should consider hormones TESTING and assessment for determining the need for and the monitoring of bio-identical hormone replacement therapy (BHRT).

1. Are you currently taking hormones? Yes☐ No☐
   a. If yes, list name (i.e. Premarin, Prempro, etc)________________________________
   b. List type (i.e. cream, gel, oral, patch, under the tongue, etc.)____________
   c. List Dosages:________________________________
   d. List days of month taken:______________________________
   e. List how often and at what time of day taken:_______________________

2. Are you pre-menopausal? (menstruating) Yes☐ No☐
   a. If yes, what is the average length of your cycle? (The number of days from the 1st day of menses to your next menses)__________________________

3. Are you peri-menopausal? (irregular cycles) Yes☐ No☐
   a. If yes, how long? (Approximately how many months?)________________

4. Have you stopped menses (bleeding)? Yes☐ No☐
   a. If yes, approximately how long since your last period/menses?_________

5. Are you post-menopausal? Yes☐ No☐
   a. If yes, how long (without menses) in years and months________________

6. Are you trying to become pregnant? Yes☐ No☐
    a. If yes, are you experiencing a fertility problem? Yes☐ No☐
    b. If you are experiencing a fertility problem, please explain briefly:

    ____
    ____
    ____

7. Do you experience symptoms of PMS? Yes☐ No☐
    a. If yes, please explain how you feel:

    ____
    ____
    ____
    ____

8. Do you suffer from migraine headaches? Yes☐ No☐
    a. If yes, how often do they occur?________________________
    b. If known, what day(s) of your cycle do they occur?____________________
    c. Please describe your headaches, (how they start, etc.)

    ____
    ____
    ____

9. Have you had a hysterectomy? Yes☐ No☐
   Where the ovaries removed? Yes☐ No☐
    a. Please describe the circumstances that necessitated the hysterectomy. What health problems did you have?

    ____
    ____
    ____

10. Have you experienced specific health problems since your hysterectomy?
    Yes☐ No☐
    Please explain what you feel:

    ____
    ____
    ____

11. Are you considering natural bio-identical hormone replacement?
    Yes☐ No☐
    How did you learn about bio-identical hormone replacement?

    ____
    ____

12. Have you ever had any hormone testing? Yes☐ No☐
    If yes, indicate which type: Saliva☐ Blood☐
    Do you have the results? Yes☐ No☐

13. What are your primary reasons for considering a female hormone assessment/testing?

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14. Do you have a history of hormone driven diseases/pathology (i.e. breast cancer, endometriosis, ovarian cysts, etc.)? Yes☐ No☐ If yes, please explain:

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15. Please indicate any of the following that apply to you:

- ☐ Anxiety
- ☐ Thinning Skin
- ☐ Fatigue
- ☐ Dry Skin
- ☐ Painful Intercourse
- ☐ Slow Healing
- ☐ Panic
- ☐ Hot Flashes
- ☐ Vaginal Dryness/Thinning
- ☐ Lethargy
- ☐ Reduced Libido
- ☐ Depression
- ☐ Hair Loss
- ☐ Irregular Menstruation
- ☐ Loss of Appetite
- ☐ Malaise
- ☐ Osteoporosis
- ☐ Weight Gain
- ☐ Poor Concentration
- ☐ Heart Disease
- ☐ Poor Memory
- ☐ Disturbed Sleep
- ☐ Arteriosclerosis

16. Do you experience difficulty in falling asleep? Yes☐ No☐

17. Does your mind race (can't turn off thinking)? Yes☐ No☐

18. Are you physically unable to relax (muscles feel tight)? Yes☐ No☐

19. Do you recall your dreams? Yes☐ No☐

20. Do you frequently have nightmares? Yes☐ No☐

21. Do you frequently have night sweats? Yes☐ No☐

22. Do you have a family history of cancer? Yes☐ No☐
    If yes, explain:
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    ____
    ____

23. Do you have a family history of heart trouble? Yes☐ No☐
    If yes, explain:
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    ____
    ____

24. Do you have a family history of Osteoporosis? Yes☐ No☐
    a. If yes, have you had a DEXA bone scan? Yes☐ No☐
    Please describe:
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    ____
    ____
    ____

25. Do you have any concerns and/or expectations regarding Bio-identical Hormone Replacement Therapy? Yes☐ No☐
    Please explain:
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