Hormone Questionnaire

Patient Name________________________________ Birth Date______________________

Address______________________________City/State________________ Zip________

Social Security Number____________________E-Mail______________________________

Home # ___________________________Cell # ___________________________________

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*Hormones are the body's biochemical messenger system. Tiny amounts of hormones are released directly into the bloodstream and exert profound effects on body processes.

*Hormones are a main part of the body's control system. They are involved in coordinating and integrating the body, as well as mind and emotions.

Do you have or have you been diagnosed with any of the following:

Vaginal Yeast Infections (Candida)
Uterine Polyps
Vaginal Dysplasia
Endometriosis
Uterine Fibroids
Polycystic Ovarian Syndrome
Ovarian Cysts
Cervical Dysplasia
Estrogen Dominance
Intrauterine Endometriosis
Infertility
Depression
Abnormal Pap Smear
Insulin Resistance
Anemia

Diabetes
Hypothyroidism
Hyperthyroidism
Adrenal Fatigue
Fibromyalgia
Chronic Fatigue Syndrome
Recurrent Bladder Infections
Human Papilloma Virus
Osteopenia or Osteoporosis
An Autoimmune Disorder
Which one?__________________________
Gall Bladder Problems
Cancer
What Type?__________________________

Place a check next to the symptoms that currently apply to you:

Nervous Tension
Restlessness
Mood Swings
Irritability
Feel out of Control
Feeling of Hopelessness
Short Fuse
Severe Temper
Rage
Anxiety
Over Sensitive
Depression
Forgetfulness
Sadness
Crying
Confusion
Headaches
Migraines
Sweet Cravings
Carbohydrate Cravings
Chocolate Cravings
Binge Eating
Hypoglycemia

Insulin Resistance
Heart Palpitations
Fatigue
Cold Hands / Feet
Dizziness
Candida
Breast Tenderness
Lumps
Fibrocystic Breasts
Abdominal Bloating
Belching
Gas
Indigestion
Acid Reflux
Weight Gain
Oily Skin
Excess Facial Hair
Acne
Swelling or Edema
  Lower Body
  Hands
  Eyelids
Constipation
Diarrhea
Difficulty Sleeping
Insomnia

Sleeping More Than Usual
Reduced Pain Threshold
Muscle/Joint Pain
Heavy Bleeding
Cramping
Blood Clots
Change in Sexual Interest
  Decreased
  Increased
Avoidance of Social Situations
Decreased Self-Esteem
Increased Interpersonal Conflicts
Hot Flashes
Dry Eyes
Dry Mucous Membranes
Vaginal Dryness
Urinary Frequency
Urinary Incontinence
Stretch Marks
Others:

____

____

____

(Please Turn Over)

Additional Questions:

How many days before your menstrual cycle do you experience PMS symptoms? ____________________
How long have you had these problems? ____________________
Are there other times of the month that you regularly experience any of these symptoms? ____________________

At what age did you begin menstruating? _____ First day of last cycle if still menstruating? ____________
If not currently menstruating, when was your last full cycle? ____________________
Age cycles became irregular, painful, heavy or diminished? ____________________
Do you have bleeding or spotting between cycles? ____________________
Has your PMS been increasing in severity? **Yes** / **No** Since when? ____________________
Is there anything you have found that helps alleviate some of the symptoms? ____________________

Is there anything you notice that worsens the symptoms? ____________________

Do you use or have you used oral or injected contraceptives? If yes, when, how long, and what was used?

Have you had any of the following exams? (**Mammogram, Bone Density, Pap Smear, Thermography, Blood Tests, Colonscopy, Biopsies, Physical Exam Blood Pressure or Cholesterol**) If yes, please list dates and results: ____________________

Do you have children? If yes, how many? ____________ Any miscarriages? ____________________
Have you had your ovaries removed or had a hysterectomy? If yes, when and why? ________________

Have you had any surgical procedures done on your thyroid gland? If yes, when and what was done?

Are you taking or have taken any synthetic hormones? If yes, which hormones, the dosage, and how are you taking them? ____________________

List any medications and/or over the counter medications and how often you take them: ______________

List current vitamin, herbs or supplements you are taking.____________________

Have you seen any medical doctors concerning these issues? If yes, who and what was the outcome?

List amount per week/day of any alcohol, tobacco, caffeine (sodas, chocolate, teas and/or coffee):

Do you feel you get enough sleep at night? ______ Hours per night?_______ Do you wake tired? ________
If you *are* having sleeping difficulties, if so, for how long? ____________________
Would you consider yourself a light sleeper? ______ Do you take anything to induce sleep? If yes, what and how long?____________________
What is your current body weight and height? ____________ What weight do your feel best at? ______
Have you been on diets in the past to lose or gain weight?____________________
How do you feel presently about your body?____________________
List your regular exercise program ____________________
What are your main concerns and outcome goals for consulting our office? ____________________