HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

- Name:
- Birth date: / Age:
- Address:
- Email Address:
- Home Phone: Work Phone: Cell Phone:
- Occupation:
- Emergency contact:
    - Phone number:_____
    - Relationship_____
- Ethnicity/Race:
    - Asian
    - Black
    - Hispanic
    - White
    - Other (list)
- Marital status:
    - Single
    - Partnered
    - Married
    - Separated
    - Divorced
    - Widowed
- How did you hear about us?

ALLERGIES

Mediations/Allergen	Reaction

CURRENT MEDICATIONS

Medication	Dose	Date Started

CURRENT SUPPLEMENTS (Vitamins, Minerals, Herbs)

Medication	Dose	Date Started

CURRENT MEDICAL CONDITIONS (ongoing health problems)

PREVIOUS SURGERIES (Hysterectomy)

Surgery/Procedure	Date

MEDICAL/GYNECOLOGIC CARE

Date of Last Physical Exam	
Date of Last Gynecologic Exam	
Date of Last Bone Density (DEXA) Scan	
Date of Last Mammogram	
Date of Last Colonoscopy	
Date of Last Pap Smear	

GYNECOLOGIC HISTORY

- **Age of Menstruation:_____**
- **Were/Are your periods regular? YES_____ NO_____**
- **How many days do your cycles last:_____**
- **Were/Are your cycles heavy: YES_____ NO_____**
- **Did/Do you bleed in between periods: YES_____ NO_____**
- **Did/have you ever been told you have endometriosis: YES_____ NO_____**
- **Number of pregnancies:_____ Number of children:_____**
- **Have you ever had any miscarriages with your pregnancies: YES_____ NO_____**
- **Did/Do you experience cramps with your menstrual cycles: YES_____ NO_____**
- **Did/Do you experience premenstrual symptoms: YES_____ NO_____**
    - **If yes, how many days did the symptoms last:_____**
- **Date of Last Menstrual Period:_____**
- **Age of Menopause:_____**
- **Have you had a Hysterectomy: YES_____ NO_____**
    - **If so when_____**
    - **Reason:_____**
    - **Were your ovaries removed: YES_____ NO_____**

HORMONE RELATED SYMPTOMS

Symptom	Mild	Moderate	Severe
Hot Flashes			
Night Sweats			
Vaginal Dryness			
Painful Intercourse			
Incontinence			
Foggy Thinking			
Memory Loss			
Tearfulness			

Depression			
Palpitations			
Bone Loss			
Insomina			
Headaches			
Bone/Joint Aches			
Morning Fatigue			
Afternoon Fatigue			
Allergies			
Sugar Cravings			
Salt Cravings			
Weight Gain (waist)			
Weight Gain (hips)			
Loss of Scalp Hair			
Increased Body Hair			
Ovarian Cysts			
Acne			
Mood Swings			
Breast Tenderness			
PMS			
Abnormal menses			
Nervousness			
Irritability			
Anxiousness			
Water Retention			
Cystic Breasts			
Uterine Fibroids			
Decreased Libido			
Decreased Stamina			
Rapid Aging			
High Cholesterol			
Puffy Eyes/Face			
Slow Pulse			
Decreased Sweating			
Dry Brittle Hair			
Brittle Nails			
Thinning Skin			
Infertility			
Constipation			
Rapid Heart Beat			
Thyroid Problems			
Hoarseness			
Urinary Urgency			
Low Blood Sugar			
High Blood Pressure			
Low Blood Pressure			

Extremities Numb			

MENOPAUSE HISTORY

- At what age or what year did you go through menopause? Age:_____ or Year:_____
- What type of menopause?
  - Natural Surgical (hysterectomy with removal of ovaries)
  - Medical (i.e.: cancer treatments)
- When did you begin hormone therapy? Age:_____ or Year:_____
- Why was hormone therapy prescribed for you? (check all that apply)
  - To treat hot flashes/night sweats
  - To treat other menopausal symptoms
  - To treat/reduce vaginal dryness
  - To treat bladder or urinary problems
  - I am not sure why
  - To reduce risk for heart disease
  - To reduce risk of osteoporosis
  - To reduce risk of colon cancer
  - Other (please list):
- Did you have hot flashes before you started hormone therapy? Yes No
- Did you have night sweats before you started hormone therapy? Yes No

HORMONE THERAPY DECISION INFLUENCES

- When did you discontinue hormone therapy? Month: Year:
- How did you discontinue hormone therapy?
  - Stopped suddenly
  - Weaned off slowly
- What type of hormone therapy were you on prior to stopping?
  - Premarin®(conjugated equine estrogen: [CEE])
  - PremPro® (CEE/medroxyprogesterone)
  - PremPhase® (CEE/medroxyprogesterone)
  - Estrace®/Gynodiol® (estradiol)
  - Cenestin® (conjugated estrogen)
  - Ogen® (estropipate)
  - Activella® (estradiol/norethindrone)
  - FemHRT® (ethinyl
  - estradiol/norethindrone)
  - Vivelle®,Climara®, Estraderm®, Alora®, Esclim® (estrogen only patch)
  - Combipatch® (estradiol/norethindrone acetate)

- FemRing® (vaginal ring)
- Estring® vaginal ring or
- Premarin®/Estrace® vaginal creams (local estrogens)
- Estratab®/Menest®(Esterifed estrogen)
- Estratest® (estrogen with testosterone)
- Topical estrogen gel/lotion (Estragel®, Estrasorb®)
- Evista® (raloxifine)
- Bio-identical hormones
- Cannot remember
- Other (please list):_____

- What influenced your decision to stop taking hormone therapy? (check all that apply)
  - Side effects (bloating, headache, bleeding)
  - Serious life threatening side effect (stroke, cancer, blood clot)
  - Health care provider recommended without a specific reason
  - Health care provider recommended because of current health conditions such has high blood pressure, cardiovascular disease or other illnesses
  - Your husband or life partner recommended that you should stop
  - A friend or co-worker recommended that you stop
  - Your pharmacist recommended that you stop
  - Stopped because of the cost of your prescription
  - Stopped on your own because of recent information obtained from:
    - Internet
    - Written publication
    - Television ad
    - Other:_____
- If you discontinued hormone treatment because of information you received please list what that info was about:
  - To try another type of treatment
  - Afraid of increased breast cancer risk
  - Afraid of blood clot or stroke
  - No particular reason, you just decided to stop on your own
  - Stopped on own, wanted to see how you would feel off hormones
  - Other (please list):_____
- Are you familiar with a study called the Women's Health Initiative (WHI)? Yes No
- Did the study findings influence your decision to stop hormone therapy?
  - Yes
  - No
  - I am not familiar with this study

DISCONTINUATION EXPERIENCES

- Did you experience hot flashes after you stopped hormone therapy?
    - No
    - Yes
        - How many per day?
        - How severe? Mild Moderate Severe
- Did you experience night sweats after you stopped hormone therapy?
    - Yes
        - How many per day?
        - How severe? Mild Moderate Severe
- Have your hot flashes resolved without restarting hormone therapy or alternative treatments?
    - No
    - Yes
        - Resolved within _____ months or _____days of stopping
- Are you still experiencing hot flashes?
    - No
    - Yes
        - How many per day?
        - How severe? Mild Moderate Severe
- Are you still experiencing night sweats?
    - No
    - Yes
        - How many per day?
        - How severe? Mild Moderate Severe
- Have you restarted hormone therapy?
    - No
    - Yes
- Did you restart hormone therapy because of hot flashes?
    - No
    - Yes:
- Are hot flashes/night sweats now resolved?
    - No
    - Yes
    - Partially
- If you have not restarted hormone therapy, will you?
    - No
    - Yes
    - Not sure Awaiting more information
- Have you used other alternative therapies or medications to treat hot flashes or night sweats?
    - No

- Yes

**If you answered yes to the use of alternatives to treat your hot flashes or night sweats please complete the next section "Alternative menopause treatments used to treat hot flashes or night sweats"*

ALTERNATIVE MENOPAUSE TREATMENTS USED TO TREAT HOT FLASHES OR NIGHT SWEATSALTERNATIVE MEDICINE SYSTEMS

- Acupuncture
  - Yes No
  - Helped
  - Did not help
- Ayurveda
  - Yes No
  - Helped
  - Did not help
- Homeopathy
  - Yes No
  - Helped
  - Did not help
- Traditional Chinese Medicine (TCM)
  - Yes No
  - Helped
  - Did not help

BIOLOGICALLY BASED THERAPIES (DIETARY SUPPLEMENTS)

- Black Cohosh
  - Yes No
  - Helped
  - Did not help
- Evening Primrose Oil
  - Yes No
  - Helped
  - Did not help
- Soy
  - Yes No
  - Helped
  - Did not help

- Red clover
    - Yes No
    - Helped
    - Did not help
- Bio-identical hormones
    - Yes No
    - Helped
    - Did not help
- Other (list):_____
    - Yes No
    - Helped
    - Did not help

MIND BODY METHODS

- Meditation/Relaxation
    - Yes No
    - Helped
    - Did not help
- Yoga
    - Yes No
    - Helped
    - Did not help

OTHER MEDICAL TREATMENTS

- Prescription antidepressants
    - Prozac
    - Effexor
    - Paxil
    - Lexapro
    - Celexa
    - Wellbutrin
    - Cymbalta
    - Other:_____
        - Yes No
        - Helped
        - Did not help
- Prescription antiseizure medication
    - Neurontin (gabapentine)
        - Yes No
        - Helped

        - Did not help
        - Not sure
- Prescription blood pressure medication
    - Clonidine (Catapress)
        - Yes No
        - Helped
        - Did not help
        - Not sure

HEALTH HABITS

- Exercise No exercise
    - Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
    - Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)
    - Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)
- Alcohol
    - Do you drink alcohol? Yes No
    - If yes, what kind?
        - wine
        - beer
        - liquor
    - How many drinks per week? _____
- Tobacco
    - Do smoke cigarettes? Yes No
        - How many packs per day? _____
        - How long have you smoked? Years_____