



2. Describe your menstrual periods presently (check all that apply):

- Regular                       Light                               Sporadic                               Brown Blood
- Irregular                       Heavy                               No Periods                               Bright Red Blood
- Clotty                               Premenstrual Spotting (= 3 days)                               Postmenstrual Spotting (= 3 days)

3. Have you ever had cramping or pain with your period?    Yes    No

4. Have you ever skipped periods all together?    Yes    No

5. When was your last menstrual period? \_\_\_\_\_ How long is your cycle? \_\_\_\_\_ Days

6. Do you have any bleeding between periods?    Yes    No   When? \_\_\_\_\_

7. When was your last test:

- Pap smear \_\_\_\_\_
- Cholesterol \_\_\_\_\_
- Mammogram \_\_\_\_\_
- Bone Density \_\_\_\_\_
- Hormone Panel \_\_\_\_\_
- Thyroid Panel \_\_\_\_\_

8. Have you ever taken hormones (synthetic or natural) before?    Yes    No

	Drug Name	Strength	When Used	Side Effects	Benefits
1					
2					
3					
4					
5					

9. If you discontinued the use of hormones, please briefly explain why. Additionally, please explain why you are seeking bio-identical hormone replacement therapy (HRT).

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10. Have you tried any alternative therapies or taken any herbal or homeopathic products?    Yes    No

If yes, please list them here:

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## OBSTETRICAL HISTORY

1. Are you sexually active?     Yes     No

If yes, please check how frequently you have sex below:

Rarely             Sometimes             Often

Are you satisfied with this level of sexual activity?     Yes     No

2. Are you trying to get pregnant?  Yes     No

3. Current method of birth control? \_\_\_\_\_ How long? \_\_\_\_\_

4. Past birth control and any related problems? \_\_\_\_\_

5. Have you ever had children?     Yes     No

6. Number of: pregnancies \_\_\_\_\_ deliveries \_\_\_\_\_ miscarriages \_\_\_\_\_

## GYNECOLOGICAL HISTORY

1. Have you had a hysterectomy?  Yes     No    If yes, when? \_\_\_\_\_

2. Have you had any part of or your whole ovary(ies) removed?     Yes     No    If yes, when? \_\_\_\_\_

3. Have you ever had a tubal ligation?     Yes     No    If yes, when? \_\_\_\_\_

4. Have you ever had an abnormal pap?     Yes     No

If yes, what was the abnormality and how was it treated?

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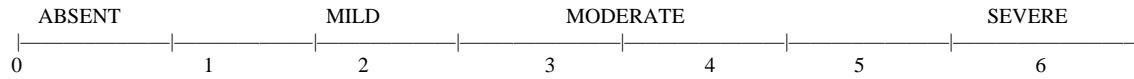
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5. Please check any of the following conditions you have had in the past or currently have:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> HSV (vaginal herpes)                     | <input type="checkbox"/> Cervical cancer    | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> HPV (vaginal warts)                      | <input type="checkbox"/> Cervical dysplasia | <input type="checkbox"/> Breast fibroids  |
| <input type="checkbox"/> Ovarian cysts                            | <input type="checkbox"/> Pelvic infections  | <input type="checkbox"/> Infertility      |
| <input type="checkbox"/> Increased facial and/or body hair growth |   |   |

## PATIENT SYMPTOM SEVERITY CHART

Please read the following list of symptoms and rate their severity on the corresponding lines using the following key:

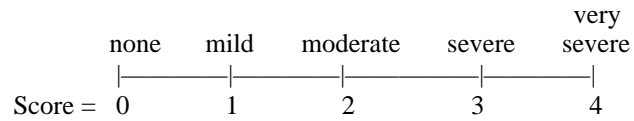


	Today	Follow-up 1	Follow-up 2	Follow-up 3
DATE	/ /	/ /	/ /	/ /
Symptoms of Low Estrogen				
Dry Skin				
Heart Palpitations				
Hot Flashes				
Inability to Reach Climax				
Night Sweats				
Painful Intercourse				
Sleep Disturbances				
Urinary Incontinence				
Urinary Tract Infections (UTIs)				
Yeast Infections				
Symptoms of Low Progesterone				
Anxiety				
Cramping				
Insomnia				
Irregular Menses				
Joint Pain				
Mood Swings				
PMS				
Swollen Breasts				
Water Retention				
Weight Gain				
Symptoms of Low Testosterone				
Blunted Motivation				
Diminished Feeling of Well Being				
Fatigue, Prolonged				
General Aches and Pains				
Muscle Weakness				
Symptoms of Both Low Estrogen and Testosterone				
Thinning Skin				
Vaginal Dryness				
Symptoms of Low Estrogen, Progesterone, and / or Testosterone				
Depression				
Fuzzy Thinking				
Hair Loss				
Headaches				
Irritability				
Low Sex Drive				
Memory Lapses				

## Menopause Rating Scale (MRS)

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark 'none'.

**Symptoms:**



- |   |                          |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Hot flushes, sweating<br>(episodes of sweating).....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Heart discomfort (unusual awareness of heart<br>beat, heart skipping, heart racing, tightness).....                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Sleep problems (difficulty in falling asleep,<br>difficulty in sleeping through, waking up early).....                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Depressive mood (feeling down, sad, on the<br>verge of tears, lack of drive, mood swings).....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Irritability (feeling nervous, inner tension,<br>Feeling aggressive).....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Anxiet (inner restlessness, feeling panicky).....  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Physical and mental exhaustion (general decrease<br>in performance, impaired memory, decrease in<br>concentration, forgetfulness)..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Sexual problems (change in sexual desire, in<br>sexual activity and satisfaction).....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Bladder problems ( difficulty in urinating,<br>increased need to urinate, bladder incontinence).....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Dryness of vagina (sensation of dryness or burning<br>in the vagina, difficulty with sexual intercourse).....                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Joint and muscular discomfort (pain in the joints,<br>Rheumatoid complaints).....   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |