DMA Weight & Wellness

Female HRT Questionnaire

History of Cancer? Yes / NO

If so, type and when: _____

History of Heart Disease, Diabetes, Liver Disease, or Kidney Disease? Yes / No

Do you have a period? Yes / No If so is it? REGULAR/IRREGULAR

Date of last period? _____

What form of birth control are you using? _____

Last Pap Smear: _____ Last Mammogram: _____

Do you have any of the following symptoms? Circe the all that apply

Anxiety	Agitation	Mood Swings	Water Retention
Bloating	Insomnia	Headaches	Sleep disturbances
Depression	Dizziness	Breast Tenderness	Breast Swelling
Night Sweats	Hot Flashes	Fatigue	Decreased libido
Vaginal Dryness	Vaginal Itching	Memory Loss	Heart palpitations
Loss of libido	Oily Skin	Acne	Cold/Heat Intolerance
Constipation	Muscle Aches	Joint Pain	Exercise Intolerance
Decreased muscle mass		Hair Loss	Lack of self confidence
Difficulty losing weight	Weight gain (especially around the middle)		

What are your goals with Hormone Therapy?

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