FEMALE HORMONE QUESTIONNAIRE

Complete this page if you are being evaluated for female hormone-related symptoms.

MENSTRUAL / REPRODUCTIVE HISTORY

Last menstrual period:	Cycles: ☐ Regular ☐ Irregular ☐ None
Typical cycle length: _____ days	Bleeding: ☐ Light ☐ Moderate ☐ Heavy
Pregnancies: _____ Live births: _____	Currently pregnant? ☐ No ☐ Yes ☐ Unsure
Breastfeeding? ☐ No ☐ Yes	Contraception: _____
Hysterectomy? ☐ No ☐ Yes, year: _____	Ovaries: ☐ Both ☐ One ☐ Neither ☐ Unsure
Menopause? ☐ No ☐ Perimenopause ☐ Postmenopause	Approx. age/year periods stopped: _____

SYMPTOM CHECKLIST

☐ Hot flashes	☐ Night sweats	☐ Sleep problems
☐ Fatigue / low energy	☐ Brain fog	☐ Memory concerns
☐ Mood changes / irritability	☐ Anxiety	☐ Depressed mood
☐ Low motivation	☐ Weight gain	☐ Difficulty losing weight
☐ Low libido	☐ Vaginal dryness	☐ Pain with intercourse
☐ Urinary symptoms	☐ Headaches	☐ Hair thinning/loss
☐ Dry skin	☐ Acne	☐ Breast tenderness
☐ Bloating	☐ Irregular periods	☐ Heavy periods
☐ PMS symptoms	☐ Joint/muscle aches	☐ Cold intolerance
☐ Heat intolerance	☐ Palpitations	☐ Other

SYMPTOM PRIORITIES

Top 3 symptoms you want addressed: 1)	2)
3)	When did symptoms begin?
Anything that makes symptoms better/worse?	

BREAST / GYNECOLOGIC SCREENING

Last mammogram: _____ Result: ☐ Normal ☐ Abnormal ☐ N/A	Last Pap/HPV: _____ Result: ☐ Normal ☐ Abnormal ☐ N/A
History of abnormal mammogram/Pap, breast biopsy, endometrial hyperplasia, unexplained vaginal bleeding, or gynecologic cancer? ☐ No ☐ Yes	
If yes, explain:	

CURRENT HORMONE PRODUCTS

Product / dose / route / frequency:	
Last dose/date used:	Prescriber:

Please bring or provide recent relevant lab and screening results if available. Your pharmacist may recommend follow-up with your prescriber before therapy is started or changed.