Beverly Medical Center
Bioidentical Hormone Replacement Questionnaire **Date_____**

Personal Data		
Name	DOB	Age
Address	City / State	Zip
Home Phone	Cell Phone	
Email	Referred By	

Primary Care Physician		
Name	Phone	
Address	City/State	Zip

Present Symptoms

Please briefly describe your symptoms.

What do you feel is the most important factor to your present symptoms?

Past Medical History

Please list any medical problems or illnesses you have had or have. Include any hospitalizations and accidents with approximate dates.

Date	

Medications: Please list ALL prescription medications. Include ALL over the counter medications, **supplements, and vitamins.**

Name of Medication	Dosage	Dosing schedule

Family History

Please list ALL illnesses (heart disease, stroke, diabetes, hypertension, cancer of any kind, etc). If a member is deceased, please list age at death and cause of death if known.

Relationship	Age	Medical Problem / Cause of death
Mother		
Father		
Brothers		
Sisters		
Children		
Spouse		

Social History

Please remember this information is strictly confidential and will be used only to address you symptoms and/or complaints.

Do you smoke cigarettes now or have you in the past?

☐ Yes ☐No

• If yes, how many packs per day? _____ • How many total years have you smoked? _____

Do you drink alcohol?

☐ Yes ☐ No

• If yes, how many drinks and what kind (wine, beer, bourbon, etc.) do you have in an average week?
_____.

Do you now or have you in the past used any illicit drugs (marijuana, amphetamines, narcotics, psychedelics, cocaine, etc.)?

☐ Yes ☐ No

• If yes, what substance and how often_____.

Urological History

Date of last prostate exam? _____

Physician who performed? _____

Physician's Phone Number: _____.

Date of PSA blood work/? _____

Facility/Office where performed: _____

Facility/Office Phone Number: _____.

	YES	NO
Have you ever had an abnormal Prostate Exam? If yes, what was the abnormality and what follow up did you have? _____	☐	☐
Have you ever had an elevated PSA? If yes, what follow up did you have? _____	☐	☐
Have you ever had a prostate biopsy?	☐	☐
Do you have a history of any of the following **cancers**: ☐ Lung ☐ Breast ☐ Colon ☐ Prostate ☐ Skin ☐ Lymphoma ☐ Leukemia ☐ Other:	☐	☐

Hormone Therapy History

Have you been treated with any hormone replacement therapy?
If yes, please give approximate periods of treatment:

Hormone	Dose	Reason	Start Date	Stop Date

Androgen Deficiency

- ☐ Low Libido
- ☐ Sad or Grumpy
- ☐ Problem with Memory / Concentration
- ☐ Lack of Energy
- ☐ Decreased Erections
- ☐ Decreased Strength / Endurance
- ☐ Decreased Ability to Play Sports
- ☐ Hair Loss
- ☐ Lost Height
- ☐ Decreased Ability to Play Sports
- ☐ Decreased Enjoyment of Life
- ☐ Decreased Ability to Play Sports
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Recent Deterioration in Work Performance
- ☐ Decreased Muscle Mass

Adrenals Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess

- ☐ Sleep Disturbances
- ☐ Bone Loss
- ☐ Fatigue
- ☐ Weight Gain –Waist
- ☐ Loss of Muscle Mass
- ☐ Thinning Skin
- ☐ Elevated Triglycerides
- ☐ Breast Cancer
- ☐ Irritable
- ☐ Acne
- ☐ Nervous
- ☐ Anxious
- ☐ Memory
- ☐ Heart Palpitations
- ☐ Headaches
- ☐ Stress
- ☐ Cold Body Temperature
- ☐ Sugar Cravings
- ☐ Low Libido
- ☐ Hair Loss
- ☐ Increased Body Hair

Cortisol Deficiency

- ☐ Fatigue
- ☐ Sugar Craving
- ☐ Allergies
- ☐ Chemical Sensitivity
- ☐ Stress
- ☐ Cold Body Temperature
- ☐ Irritable
- ☐ Arthritis
- ☐ Heart Palpitations
- ☐ Aches/Pains

Thyroid: Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess

- ☐ Heat Intolerance
- ☐ Voice has become horse
- ☐ Palpitations
- ☐ Weight Loss
- ☐ Tremors / Shakiness
- ☐ Diarrhea
- ☐ Nervousness / Anxious / Panic Attacks
- ☐ Muscle Weakness
- ☐ Difficulty Conceiving / Infertility
- ☐ Coarse Dry Skin
- ☐ Insomnia

Thyroid Deficiency

- ☐ Cold Intolerance
- ☐ Constipation
- ☐ Fatigued / Weakness
- ☐ Unexplained Weight Gain
- ☐ Inability to Lose Weight
- ☐ Stress
- ☐ Cold Body Temperature
- ☐ Irritable
- ☐ Lack of Motivation
- ☐ Muscle Cramps
- ☐ Aches/Pains

System Review – Check the appropriate box for each question.			
	Yes	**No**	**Not Sure**
Have you had unexplained weight loss?	☐	☐	☐
Do you have fever of chills?	☐	☐	☐
Do have night sweats?	☐	☐	☐
Do you notice swollen lymph nodes?	☐	☐	☐
Have you ever been diagnosed with cancer?	☐	☐	☐
Have you ever tested positive of HIV?	☐	☐	☐
Have you ever had a sexually transmitted disease?	☐	☐	☐
Do you have a cough?	☐	☐	☐
Do you frequently sneeze?	☐	☐	☐
Do you have excessive daytime sleepiness?	☐	☐	☐
Do you snore?	☐	☐	☐
Have you ever been diagnosed with asthma, emphysema or Sleep Apnea	☐	☐	☐