Optimal Wellness Center
Your Guide to Optimal Health

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# Bioidentical Hormone Therapy Questionnaire

***Female Intake***

Date: _____

**Personal Information**

Name: *(first, last)* _____ Maiden: _____

Preferred Name: _____ Sex: M F Date of Birth: _____ Age: ____

Street Address: _____

City: _____ State: ____ Zip: _____ E-mail _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Occupation: _____ Work Phone: _____

Name of Spouse or Guardian: _____

Employer: _____ Work Phone: _____

Last Physician Consulted: _____

Reason for that visit: _____

**Emergency Contact:**

Name: _____ Phone: _____

**Who may we thank for referring you?** *(fill in and/or circle all that apply)*

Friend _____ Professional Referral _____ Event _____

Internet Flier/Brochure Ad

*Print Patient Name:* _____ *Date:* _____

What are your top health concerns?

1. _____

2. _____

3. _____

## Current Medications:

Include prescription, over the counter, and any supplements.

| Rx | Vitamins/Herbs |
|---|---|
| | |
| | |
| | |
| | |
| | |

Drug Allergies: _____

Other Allergies: _____

## Habits *(please list type, frequency and quantities)*:

Caffeine: _____

Alcohol: _____

Smoking: _____

## Exercise:

Type:

Days per week:

Cross training:

Weight training:

Competitive events:

Number of competitions per month/year:

Training group/coach:

**Diet** *(Please list typical foods eaten at these meals):*

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

Please list any foods that you avoid.

## Past Medical History:

Childhood Illnesses: _____

Adult Illnesses: _____

Hospitalizations: _____

Surgeries: _____

Injuries: _____

## Family Health History: *(cause of death and age, where applicable)*

Mother:

- Grandmother:
- Grandfather:

Father:

- Grandmother:
- Grandfather:

Siblings:

# Review of Current Symptoms

√ For Mild √√ For Moderate √√√ For Severe

**Constitutional:**
Fatigue/Tired _____
Weight Change _____
Fever/Chill/Sweats _____
Appetite Change _____
Abnormal Thirst _____
Difficulty Sleeping _____
Light-Headed _____

**Eyes:**
Dry _____
Vision _____
Tearing _____
Itching _____
Feels Heavy _____

**Ears:**
Itching _____
Hearing Problems _____
Blocked Ears _____
Ringing in Ears _____
Sensitive to Sound _____
Dizziness/Vertigo _____

**Nose/Throat:**
Stuffed/Runny Nose _____
Postnasal Drip _____
Sore Throat _____
Tight/Swollen Throat _____
Hoarse Voice _____
Trouble Swallowing _____

**Mouth:**
Dry _____
Sores/Fissures _____
Herpes or Frequent Cold sores _____
Gum/Tooth Problems _____
Tongue Problem _____

**Skin:**
Itching _____
Flushing _____
Rashes _____
Hives _____
Dry/Rough Skin _____
Acne _____
Nail Problem _____
Hair Problem _____
Tightening _____

**Lymph Nodes:**
Swollen/Tender _____

**Lungs/Heart:**
Cough _____
Wheezing _____
Shortness Breath _____
Hyperventilation _____
Phlegm/Mucus _____
Bronchitis _____
Chest Pain/Exertion _____
Other Chest Pain/Distress _____
Palpitations/Rapid/Slow _____
Irregular Heart Rate/Rhythm _____
Ankle Swelling _____
Calf Pain on Exercise _____
Sore Tender Legs _____
High Blood Pressure _____

**Gastrointestinal:**
Nausea _____
Belching/Bloating Gas _____
Passing Gas _____
Heartburn _____
Stomach Pain _____
Rectal Pain/Itching _____
Blood/Black Stool _____
Worms or Parasites _____

**Muscles:**
Tight/Stiff _____
Ache/Sore/Pain _____
Neck _____
Shoulder/Upper back _____
Low Back _____
Extremities _____
Weakness _____

**Joints:**
Ache/Pain _____
Stiff _____
Swelling _____

**G.U. & Hormonal (Female):**
Severe Menstrual Cramps _____
Severe Premenstrual Sympt _____
Menstrual Irregularity _____
Herpes _____
Frequent Vaginal Discharge _____
Yeast/Candida Infection _____
Painful/Difficult Urination _____
Pressure/Urgency/Itching _____
Vaginal Rash _____
Sexual Problems _____

**G.U (Male):**
Difficulty Voiding _____
Prostate Problem _____
Limp on Testes _____
Sexual Problem _____
Herpes _____

**Thyroid:**
Mass or Lump in Neck _____
Cold/Heat Tolerance _____
History X-Ray to Neck _____
Feel Hyper or Sluggish _____

**Neuropsychiatric:**
Headache (Mild/Moderate) _____
Headache (Severe) _____
Depression/Apathy _____
Anxiety/Irritable _____
Hyperactive _____
Learning Difficulty _____
"Brain Fog"/Difficulty Concentrating _____
Mood Swings _____
Suicidal _____
Homicidal _____
Numbness, Tingling _____
Faints/Blackouts _____
Seizures/Convulsions _____
Memory Problems _____

**Auto-Immune**
Photosensitive/Rash _____
Inflammation Heart _____
Inflammation Lung _____
Inflammation Kidney _____
Raynauds _____
(Fingers change color in the cold)

**Greater than 3 Months**
Fatigue _____
Memory Problems _____
Sore Throat _____
Lymph node tender _____
Joint Pain/Swelling _____
Headaches _____
Un-Refreshed Sleep _____
Post Exertional Fatigue _____

Tick Bite _____ Chronic Allergies _____
Rashes _____

## Women's Health

LMP (Last Menstrual Period): _____ FMP (Final Menstrual Period): _____

Menarche (First Period): _____ How long between your periods? _____

How long do you flow? _____ Do you have cramps? Y N How severe (1-10)? _____

Have you ever missed a period (and when)? _____ How often? _____

| Births (mo/yr) | Sex | Type of Delivery | Complications | Name |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Miscarriages: _____ Induced abortions: _____ Premature birth: _____

Have you ever been tested for or concerned about infertility? _____

## Have you ever taken any of the following?

Birth control pill/patch Yes No Type: _____
HRT (Hormone Replacement Therapy): Yes No Type: _____
NHRT (Natural Hormone Replacement Therapy): Yes No Type: _____
Progesterone Cream (OTC): Yes No Type: _____

Do you have an immediate family history of Breast/Uterine/Ovarian cancer? Yes No

Date of most recent Bone Density Scan (DXA)? _____ Results: _____

When was your last mammogram? _____ Results: _____

When was your last colon cancer screen? _____ Results: _____

Have you ever had fibroid tumors? _____ Ovarian cysts? _____

Do you have pain or bleeding with intercourse? _____

Are you sexually active? _____ Is/are your partner(s) male or female? _____

When was your last Pap smear? _____ Where was it done? _____

Have you ever had an abnormal Pap smear? ____ When? _____ Result? _____

What was the method of treatment? _____

Please place a number after each symptom:
0- None 2- Moderate
1- Mild 3- Severe

# Hormone Symptoms

**Progesterone Deficiency**
PMS
Insomnia
Painful breasts
Weight Gain
Anxiety
Cyclical Headaches
Infertility
Sugar craving
Irregular periods
Allergy symptoms
Joint pain
Cold hands and feet
Miscarriages
Brittle nails
Dry skin/hair
Fibromyalgia
Fibrocystic breasts
Headaches
Slow metabolism
Mood swings

**Estrogen Deficiency**
Hot flashes
Night sweats
Memory problems
Lethargic depression
Vaginal dryness
Painful intercourse
Osteoporosis/thin bones
Facial hair
Droopy breasts
Vertical lip lines
Fatigue
Decreased libido

**Adrenal Fatigue**
Fatigue
Brain fog
Thin dry skin
Brown spots on face
Low blood pressure
Intolerance to exercise

**Excess Androgens**
Acne
Thinning hair
Ovarian cysts
PCOS
Infertility

**Estrogen Dominance Progesterone< Estrogen**
Allergies
Bloating
Cervical dysplasia
Depression
Irritability
Loss of libido
Loss of memory
Mood swings
Fatigue
Hair loss
Thyroid dysfunction
Weight gain

**Estrogen Excess**
Puffiness and bloating
Rapid weight gain
Mood swings
Anxious depression
Insomnia
Breast tenderness
Heavy bleeding
Migraine headaches
Brain fog

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## ESTROGEN (for Women only)

| | SIGNS & SYMPTOMS | NEVER | SOMETIMES | REGULARLY | OFTEN | CONSTANTLY |
|---|---|---|---|---|---|---|
| 1 | I am losing hair on top of my head. | 0 | 1 | 2 | 3 | 4 |
| 2 | I am getting thin, vertical wrinkles above my lips. | 0 | 1 | 2 | 3 | 4 |
| 3 | My breasts are droopy. | 0 | 1 | 2 | 3 | 4 |
| 4 | My face is too hairy. | 0 | 1 | 2 | 3 | 4 |
| 5 | My eyes are dry and easily irritated. | 0 | 1 | 2 | 3 | 4 |
| 6 | I have hot flashes. | 0 | 1 | 2 | 3 | 4 |
| 7 | I feel tired constantly. | 0 | 1 | 2 | 3 | 4 |
| 8 | I am depressed. | 0 | 1 | 2 | 3 | 4 |
| 9 | My menstrual flow is light. (0=moderate / 1-3=low / 4=none) | 0 | 1 | 2 | 3 | 4 |
| 10 | Women with periods: My cycles are irregular, too short (<27 days), or too long (>31 days). | 0 | 1 | 2 | 3 | 4 |
| 11 | Women without periods: I do not feel like making love anymore. | 0 | 1 | 2 | 3 | 4 |

Add up your Overall Score_____: Overall total of 10 or less is satisfactory level; Between 11-20 – possible estrogen deficiency; 21 or more – probable estrogen deficiency.

## PROGESTERONE (for Women only)

| | SIGNS & SYMPTOMS | NEVER | SOMETIMES | REGULARLY | OFTEN | CONSTANTLY |
|---|---|---|---|---|---|---|
| 1 | My breasts are large. | 0 | 1 | 2 | 3 | 4 |
| 2 | My close friends complain I'm nervous and agitated. | 0 | 1 | 2 | 3 | 4 |
| 3 | I sleep lightly and restlessly. | 0 | 1 | 2 | 3 | 4 |
| 4 | The following questions are for women who have not yet reached menopause, and menopausal women who are taking hormone replacement therapy (estrogen or estrogen and progesterone) | 0 | 1 | 2 | 3 | 4 |
| 5 | My breasts are swollen and tender or painful before my period. | 0 | 1 | 2 | 3 | 4 |
| 6 | And my lower belly is swollen. | 0 | 1 | 2 | 3 | 4 |
| 7 | And I'm irritable and aggressive. | 0 | 1 | 2 | 3 | 4 |
| 8 | And I lose my self-control. | 0 | 1 | 2 | 3 | 4 |
| 9 | I have heavy periods. | 0 | 1 | 2 | 3 | 4 |
| 10 | And they are continuously painful. | 0 | 1 | 2 | 3 | 4 |

Add up your Overall Score_____: Post-menopausal ***not*** treated with hormone replacement therapy (estrogen or estrogen and progesterone): ***4 or less*** – Satisfactory level; ***Between 5 and 8*** – Possible progesterone deficiency; ***9 or more*** – probable progesterone deficiency. Menstrual and menopausal women taking hormone replacement therapy (estrogen or estrogen and progesterone); ***10 or less*** – Satisfactory level; ***Between 11 and 20*** – possible progesterone deficiency; ***21 or more*** – probable progesterone deficiency.

## TESTOSTERONE (for Men and Women)

| | SIGNS & SYMPTOMS | NEVER | SOMETIMES | REGULARLY | OFTEN | CONSTANTLY |
|---|---|---|---|---|---|---|
| 1 | My face has gotten slack and more wrinkled. | 0 | 1 | 2 | 3 | 4 |
| 2 | I've lost muscle tone. | 0 | 1 | 2 | 3 | 4 |
| 3 | My belly tends to get fat. | 0 | 1 | 2 | 3 | 4 |
| 4 | I'm constantly tired. | 0 | 1 | 2 | 3 | 4 |
| 5 | I feel like making love less often than I used to. **(MEN ONLY)** | 0 | 1 | 2 | 3 | 4 |
| 6 | My breasts are getting fatty. | 0 | 1 | 2 | 3 | 4 |
| 7 | I feel less self-confident and more hesitant. | 0 | 1 | 2 | 3 | 4 |
| 8 | My sexual performance is poorer than it used to be. | 0 | 1 | 2 | 3 | 4 |
| 9 | I have hot flashes and sweats. | 0 | 1 | 2 | 3 | 4 |
| 10 | I tire easily with physical activity. | 0 | 1 | 2 | 3 | 4 |

Add up your Overall Score_____: For Women; ***5 or less*** – Satisfactory level; ***Between 6 and 10*** – possible testosterone deficiency; ***11 or more*** – probable testosterone deficiency. For Men; ***10 or less*** – Satisfactory level; ***Between 11 and 20*** – possible testosterone deficiency; ***21 or more*** – probable testosterone deficiency.

Betty Keller M.D.

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## DHEA

| | SIGNS & SYMPTOMS | NEVER | SOMETIMES | REGULARLY | OFTEN | CONSTANTLY |
|---|---|---|---|---|---|---|
| 1 | My hair is dry. | 0 | 1 | 2 | 3 | 4 |
| 2 | My skin and eyes are dry. | 0 | 1 | 2 | 3 | 4 |
| 3 | My muscles are flabby. | 0 | 1 | 2 | 3 | 4 |
| 4 | My belly is getting fat. | 0 | 1 | 2 | 3 | 4 |
| 5 | I don't have much hair under my arm. | 0 | 1 | 2 | 3 | 4 |
| 6 | I don't have much hair in the pubic area. (0=plenty / 4=hairless) | 0 | 1 | 2 | 3 | 4 |
| 7 | I don't have much fatty tissue in my pubic area. (flat "mound of Venus" in women) (0=padded / 4=flat) | 0 | 1 | 2 | 3 | 4 |
| 8 | My body doesn't have much of a special scent during sexual arousal. | 0 | 1 | 2 | 3 | 4 |
| 9 | I can't tolerate noise. | 0 | 1 | 2 | 3 | 4 |
| 10 | My libido is low. | 0 | 1 | 2 | 3 | 4 |

Add up your Overall Score_____: Overall total of 10 or less is satisfactory level; Between 11-20 – possible DHEA deficiency; 21 or more – probable DHEA deficiency.

## PREGNENOLONE

| | SIGNS & SYMPTOMS | NEVER | SOMETIMES | REGULARLY | OFTEN | CONSTANTLY |
|---|---|---|---|---|---|---|
| 1 | I have memory loss. | 0 | 1 | 2 | 3 | 4 |
| 2 | My joints hurt (fingers, wrists, elbows, feet, ankles, knees). | 0 | 1 | 2 | 3 | 4 |
| 3 | I am feeling a bit drained and I have a hard time handling stress. | 0 | 1 | 2 | 3 | 4 |
| 4 | I don't see colors and brightly as before. | 0 | 1 | 2 | 3 | 4 |
| 5 | I don't have much hair under my arms or in the pubic area. (0=plenty of hair / 4=hairless) | 0 | 1 | 2 | 3 | 4 |
| 6 | My muscles are flabby. | 0 | 1 | 2 | 3 | 4 |
| 7 | I have abundant, light-colored urine during the day. | 0 | 1 | 2 | 3 | 4 |
| 8 | I have low blood pressure. | 0 | 1 | 2 | 3 | 4 |
| 9 | I crave salty foods. | 0 | 1 | 2 | 3 | 4 |

Add up your Overall Score_____: Overall total of 10 or less is satisfactory level; Between 11-20 – possible pregnenolone deficiency; 21 or more – probable pregnenolone deficiency.

## THYROID

| | SIGNS & SYMPTOMS | NEVER | SOMETIMES | REGULARLY | OFTEN | CONSTANTLY |
|---|---|---|---|---|---|---|
| 1 | I'm sensitive to cold. | 0 | 1 | 2 | 3 | 4 |
| 2 | My hands and feet are always cold. | 0 | 1 | 2 | 3 | 4 |
| 3 | In the morning my face is puffy and my eyelids are swollen. | 0 | 1 | 2 | 3 | 4 |
| 4 | I put on weight easily. | 0 | 1 | 2 | 3 | 4 |
| 5 | I have dry skin. | 0 | 1 | 2 | 3 | 4 |
| 6 | I have trouble getting up in the morning. | 0 | 1 | 2 | 3 | 4 |
| 7 | I feel more tired at rest than when I am active. | 0 | 1 | 2 | 3 | 4 |
| 8 | I am constipated. | 0 | 1 | 2 | 3 | 4 |
| 9 | My joints are stiff in the morning. | 0 | 1 | 2 | 3 | 4 |
| 10 | I feel like I'm living in slow motion. | 0 | 1 | 2 | 3 | 4 |

Add up your Overall Score_____: Overall total of 10 or less is satisfactory level; Between 11-20 – possible thyroid deficiency; 21 or more – probable thyroid deficiency.

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