Ford's
fordrx.com | info@fordrx.com
FAMILY PHARMACY & WELLNESS CENTRE

Hormone Questionnaire
General Information

Name: _____ Age: _____ Birth Date: _____
month day year

Street Address: _____

City: _____ Prov: _____ Postal Code: _____

E-mail address: _____

Home Phone #: _____ Work Phone #: _____

_

Height: _____ Weight: _____ Blood Type: _____

Are you presently on any prescription drugs? Yes ____ No _____

If yes, are they filled at Ford's Apothecary? Yes ____ No _____

If your prescriptions are not presently being filled with us, would you be interested in having them transferred to Ford's Apothecary? Yes _____ No _____

If yes, please contact the pharmacy at 506-853-0830 or 888-644-3673.

How did you hear about Natural Hormone Replacement?

☐ Advertisement: ☐ Another Patient: ☐ Physician/Healthcare practitioner:

☐ Courses/seminar: ☐ Books/articles: Other: _____

Do you understand what Natural (Bio-Identical) Hormone Replacement is?

What are your goals for Natural Hormone Replacement?

Medical Status

General Health: Good: ☐ Fair: ☐ Poor: ☐

Current diagnosis or medical conditions: _____

_____

Drug allergies: _____

Allergies to food, pollen, etc.: _____

Current medications: _____

_____

Current vitamins or Over-the-Counter (OTC) products:

_____

_____

Current herbs / etc.:

_____

_____

Have you had your cholesterol level checked? Yes ☐ No ☐ Date: _____

Results: _____

Have you had a mammogram? Yes ☐ No ☐ Date: _____

Results: _____

Have you had a bone density scan? Yes ☐ No ☐ Date: _____

Results: _____

Current / Recent Health Care Providers:

_____

_____

_____

_____

Past Medical Conditions

Childhood diseases: _____

Adult Health Conditions:

☐ Heart condition	☐ High Blood Pressure	☐ Asthma	☐ Stroke
☐ Varicose Veins	☐ Clotting Defects	☐ Diabetes	☐ Kidney Trouble
☐ Fractures	☐ Arthritis	☐ Colitis	☐ Gallbladder Trouble
☐ Chronic Fatigue	☐ Fibromyalgia	☐ Eating Disorder	☐ Cancer

Other: _____

Habits

Dietary Restrictions:

Meal Choices:

Breakfast _____

Lunch _____

Dinner _____

Do you get routine physical exercise? Yes ☐ No ☐

What type: _____

Do you use tobacco products? Yes ☐ No ☐ If yes, how much? _____

Previously How long? _____

Do you use alcohol products? Yes ☐ No ☐ If yes, how much? _____

Previously How long? _____

Do you use caffeine products? Yes ☐ No ☐ If yes, how much? _____

Family History

Please list family members and their age who are still living that may have important diseases such as: high blood pressure, heart disease, cancer, diabetes, osteoporosis, etc.

_____

_____

_____

_____

_____

Please list family members who died of important diseases, (see above questions), what the disease was and their age at the time of death.

_____

_____

_____

Gynecological History

Age at first period: _____ Date of last period: _____

Date of last pelvic exam: _____ Pap smear: _____

Results:
Have you ever had an abnormal pap: Yes ☐ No ☐
Treatment, if yes _____

Are you sexually active: Yes ☐ No ☐ Are you trying to get pregnant: Yes ☐ No ☐

Current birth control method: _____ How long? _____

Any problem with it? _____ How long? _____

Past birth control and any related problems: _____

How many days from start of one period to the next? _____

Number of days of flow: _____ Amount of bleeding: _____

Amount of cramps: _____

Premenstrual symptoms: _____

Starting and ending when? _____

Any current changes in your normal cycle? _____

Any bleeding between periods: _____ When: _____

Any pelvic pain, pressure, or fullness: Yes ☐ No ☐
Explain, if yes: _____

Any unusual vaginal discharge or itching? Yes ☐ No ☐
Describe, if yes: _____

Treatment: _____

Age of first pregnancy: _____ How many full term pregnancies? _____
Problems: _____

Any interrupted pregnancies (miscarriages or abortions)? Yes ☐ No ☐

Have you had a tubal ligation: _____ When? _____

Have you had any part or a whole ovary removed: Yes ☐ No ☐ When? _____

Have you had a hysterectomy? Yes ☐ No ☐ When, if yes. _____

Do your ovaries remain? _____

Symptoms I (Circle absent, mild, moderate or severe for each symptom. If you feel a range of 2 is more accurate, such as mild and moderate, choose both)

Headaches	Absent	Mild	Moderate	Severe
Low libido	Absent	Mild	Moderate	Severe
Anxiety	Absent	Mild	Moderate	Severe
Swollen breasts	Absent	Mild	Moderate	Severe
Moodiness	Absent	Mild	Moderate	Severe
Fuzzy thinking	Absent	Mild	Moderate	Severe
Depression	Absent	Mild	Moderate	Severe
Food cravings	Absent	Mild	Moderate	Severe
Irritability	Absent	Mild	Moderate	Severe
Insomnia	Absent	Mild	Moderate	Severe
Cramps	Absent	Mild	Moderate	Severe
Emotional swings	Absent	Mild	Moderate	Severe
Pain in breasts	Absent	Mild	Moderate	Severe
Weight gain	Absent	Mild	Moderate	Severe
Bloating	Absent	Mild	Moderate	Severe

Symptoms II (Circle absent, mild, moderate or severe for each symptom. If you feel a range of 2 is more accurate, such as mild and moderate, choose both)

Hot flashes	Absent	Mild	Moderate	Severe
Shortness of breath	Absent	Mild	Moderate	Severe
Night sweats	Absent	Mild	Moderate	Severe
Sleeping disorders	Absent	Mild	Moderate	Severe
Vaginal dryness	Absent	Mild	Moderate	Severe
Dry hair / skin	Absent	Mild	Moderate	Severe
Hair loss	Absent	Mild	Moderate	Severe
Anxiety	Absent	Mild	Moderate	Severe
Mood swings	Absent	Mild	Moderate	Severe
Headaches	Absent	Mild	Moderate	Severe
Depression	Absent	Mild	Moderate	Severe
Short term memory loss	Absent	Mild	Moderate	Severe
Frequent urinary tract infections	Absent	Mild	Moderate	Severe
Heart palpitations	Absent	Mild	Moderate	Severe
Inability to reach orgasm	Absent	Mild	Moderate	Severe
Loss of pubic hair	Absent	Mild	Moderate	Severe
Painful intercourse	Absent	Mild	Moderate	Severe

Symptoms III (Circle absent, mild, moderate or severe for each symptom. If you feel a range of 2, such as mild and moderate, is more accurate, choose both)

Water retention	Absent	Mild	Moderate	Severe
Fatigue, lack of energy	Absent	Mild	Moderate	Severe
Breast swelling	Absent	Mild	Moderate	Severe
Fibrocystic breasts	Absent	Mild	Moderate	Severe
Premenstrual mood swings	Absent	Mild	Moderate	Severe
Loss of sex drive	Absent	Mild	Moderate	Severe
Heavy or irregular menses	Absent	Mild	Moderate	Severe
Uterine fibroids	Absent	Mild	Moderate	Severe
Craving for sweets	Absent	Mild	Moderate	Severe
Weight gain (hips & thighs)	Absent	Mild	Moderate	Severe
Symptoms of low thyroid	Absent	Mild	Moderate	Severe

Patient Menopausal Diary

Self-assessment: On a scale of 1 to 3, keep track of how often you have the following symptoms (1 is mild, 2 is moderate, 3 is severe)

Symptoms	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Hot flashes							
Sweating, night sweats							
Heart palpitations							
Itchy, crawling skin							
Menstrual irregularities							
Vaginal dryness							
Urinary problems							
Joint, muscle pain							
Headache							
Dry skin							
Thinning hair							
Oral discomfort							
Mood swings							
Anxiety, apprehension							
Depression							
Insomnia							
Forgetfulness							
Change in sexual behaviour							