HRT QUESTIONAIRE **DATE 1st visit: / /** **DR SALOMI ROY**

Please answer these questions before you come for your consultation to facilitate your treatment, (not all questions may be relevant to you).

Name: …. **Age: ….**

Main Problem/s you are seeking help for: ….

….

Past History: Surgical: Hysterectomy Y N. If Y, for what reason.....

Oophorectomy (ovaries removed) Y N only one or both?

Other operations ….

Medical: Blood Clots Y N

Breast problems .....

Other ….

….

Current Treatment (include vitamins & natural medicines)

*** ….** *** ….**

*** ….** *** ….**

*** .....** *** ….**

*** ….** *** ….**

Previous hormone treatment: ….

Side affects of hormone treatment? ….

Do you have a regular mammogram? Y N When was your last PAP smear? ….

Allergies: ….

Bad habits: Do you smoke? Y N, drink more than two alcoholic drinks daily (average) Y N

Family history: Mother: Breast disease Y N Osteoporosis Y N

Blood clots Y N Heart disease Y N

Other ….

Father: .....

Sister/s: ….

Have you had any blood or saliva hormone tests recently? Y N

SYMPTOMS LIST: Please **score** each of the following from **0** (not experienced) to **3** (severe symptoms).

Heavy or irregular periods	[ ]	Social withdrawal	[ ]
Fatigue	[ ]	Low self-esteem	[ ]
Breast swelling/tenderness	[ ]	Depression	[ ]
Weight gain	[ ]	Indigestion	[ ]
Fluid retention	[ ]	Anxiety or panic	[ ]
Breast cysts/lumps	[ ]	Vertigo	[ ]
Premenstrual mood swings	[ ]	Crawling skin	[ ]
Body aches & pains	[ ]	Poor libido (sex drive)	[ ]
Headaches or migraines	[ ]	Fibroids	[ ]
Sleep disturbances	[ ]	Thrush	[ ]
Night sweats	[ ]	Acne	[ ]
Hot flushes	[ ]	Irritability	[ ]
Confusion/disorientation	[ ]		