Robert D. Wilcox, M.D. **FEMALE** **J. Michael Morrissey, M.D.**

PLASTIC & COSMETIC
SURGERY CENTER OF TEXAS

972-620-1700

HRT Questionnaire For Female

Patient Name: _____ Date of Birth: _____

How did you hear about hormone replacement therapy?

( ) Another Patient ( ) Books / Articles ( ) Ads ( ) Physician ( ) Other

_____

Have you previously had any type of Hormone Replacement Therapy? ( ) Yes ( ) No

If yes, please explain: _____

Current Lifestyle & Habits

Please describe any dietary restrictions: _____

Common Meal Choices:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you exercise? ( ) Yes ( ) No How Often? _____ Type of exercise: _____

Do you use caffeine products? ( ) Yes ( ) No How Often? _____ Type: _____

Gynecological History:

Date of last pelvic exam: _____ Results: _____

Date of last pap-smear: _____ Results: _____

Have you ever had an abnormal pap-smear? _____ ( ) Yes ( ) No

If yes, Treatment: _____

Are you sexually active? ( ) Yes ( ) No Are you trying to get pregnant? ( ) Yes ( ) No

Current Birth Control Method: _____ Any problems? _____ How long? _____

Past Birth Control Method and any related problems: _____

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

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

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

Premenstrual symptoms: _____ Start and end when: _____

Any current changes in your normal cycle? ( ) No ( ) Yes / If Yes, explain: _____

Any bleeding between periods? ( ) No ( ) Yes / If yes, when? _____

Any pelvic pain, pressure or fullness? ( ) No ( ) Yes / If yes, please describe: _____

Any Pelvic pain, pressure or fullness? ( ) No ( ) Yes / If yes, please describe: _____

Any unusual vaginal discharge or itching? ( ) No ( ) Yes / describe: _____ Treatment; _____

Age at first pregnancy: _____ How many full term pregnancies: _____

Any issues with pregnancy: ( ) No ( ) Yes / If yes, please describe; _____

Any iterated pregnancies (miscarriages or abortions) ( ) No ( ) Yes

Have you had tubal ligation? ( ) No ( ) Yes / If yes, When? _____

Have you any part of or a whole ovary removed: ( ) No ( ) Yes

Have you had a hysterectomy: ( ) No ( ) Yes / If yes, When: _____

Do your ovaries remain: ( ) No ( ) Yes

General Health

Have you experienced any of the following lately? Circle the number that best describes your experiences on a scale from 0 – 10. (*For example: 0 = non-existent, 1 = very mild, 10 = extremely severe*)

Severity	**None**										**Extreme**
Sleep Disruptions	0	1	2	3	4	5	6	7	8	9	10
Fatigue	0	1	2	3	4	5	6	7	8	9	10
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Nervousness	0	1	2	3	4	5	6	7	8	9	10
Breast Tenderness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Arthritis	0	1	2	3	4	5	6	7	8	9	10
Loss of recent memory	0	1	2	3	4	5	6	7	8	9	10
Weight Gain	0	1	2	3	4	5	6	7	8	9	10
Decreased sex drive	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Fluid Retention	0	1	2	3	4	5	6	7	8	9	10
Headaches	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Difficulty reaching climax	0	1	2	3	4	5	6	7	8	9	10
Bladder Symptoms	0	1	2	3	4	5	6	7	8	9	10
Other:											
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10
_____	0	1	2	3	4	5	6	7	8	9	10

_____ _____

Patient Name Date

_____

Signature