Optimal Health Montana
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Disclosure: OHM always keeps your information private. However, we do not have encryption ability for your questionnaire. Please only fill in what you are comfortable with, knowing that we NEVER share your information!

HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

Name:_____ Date of Birth:_____ Age:_____ Sex: ☐ Female ☐ Male

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Occupation or previous occupation, if retired:_____

Emergency Contact Name:_____ Emergency Contact Phone:_____

How did you hear about us?

☐ Social Media:_____ ☐ Referral:_____

☐ Internet Search ☐ Other:_____

PLEASE RATE YOUR CURRENT SYMPTOMS:

1 - Mild 2 - Moderate 3 - Severate **If no symptoms, leave box blank**

Estrogens:

- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Depression
- ☐ Brain Fog
- ☐ Fatigue/ Low Energy
- ☐ Weight Gain
- ☐ Decreased Sensuality
- ☐ Pain During Intercouse
- ☐ Urinary Leakage
- ☐ Droopy Breasts
- ☐ Dry,Dehydrated Skin
- ☐ Vaginal Dryness
- ☐ Thinning Skin
- ☐ Loss of Glow
- ☐ Dry Eyes*
- ☐ Vertical Lines Around Mouth
- ☐ High Cholesterol
- ☐ Vaginal Itching
- ☐ Back and Join Paint
- ☐ Low Bone Density*

Signs of Excess
- ☐ Breast Tenderness
- ☐ Breast Fullness
- ☐ Nipple Tenderness
- ☐ Fluid Retention

Progesterone:

- ☐ Difficulty falling & staying asleep
- ☐ Irritability
- ☐ Anxious
- ☐ Mood Swings
- ☐ Unable to Relax
- ☐ Hot Flashes
- ☐ Swollen, Painful Breasts
- ☐ Breast Lumps/Fibrocystic Breasts
- ☐ Swollen Feet and Ankles
- ☐ Period Irregularities
- ☐ Scanty Menstruation
- ☐ Heavy Bleeding
- ☐ PMS
- ☐ Fibroids/ Endometriosis
- ☐ History of Infertility
- ☐ History of Miscarriage
- ☐ Headaches
- ☐ Acne
- ☐ Swollen Face
- ☐ Low Bone Density

Signs of Excess
- ☐ Drowsiness

Testosterone/ DHEA:

- ☐ Loss of Muscle
- ☐ Abdominal Weight Gain
- ☐ Cellulite
- ☐ Varicose Veins
- ☐ Loss of Libido
- ☐ Lack of Orgasm
- ☐ Low Clitoral Sensitivity
- ☐ Dry Eyes
- ☐ Loss of Confidence
- ☐ Low Energy/Stamina
- ☐ Digestive Issues
- ☐ Poor Tissue Repair
- ☐ Immune Dysfunction
- ☐ Low Bone Density*
- ☐ Unwanted Hair Growth
- ☐ Voice Changes
- ☐ Aggression
- ☐ Oiliness of Skin
- ☐ Hair Loss on Head
- ☐ Acne*

Signs of Excess

*Multiple Reasons for this Symptom

Have you ever used Hormone Replacement Therapy (HRT) in the past? Check all that apply: ☐ Yes ☐ No

☐ Estrogen ☐ Human Growth Hormone ☐ Progesterone ☐ Testosterone
☐ Estrogen Blocker ☐ Oestrogen ☐ Progestin ☐ Tibolone

If you have ever used Hormone Replacement Therapy (HRT) in the past, please mark all forms you've tried:

☐ Buccal Tablet ☐ Injection (IM) ☐ Intravaginal Ring ☐ Oral Tablet
☐ Creams (Topical) ☐ Intravaginal Cream ☐ Intrauterine Device ☐ Patch (Topical)
☐ Gels (Topical) ☐ Intravaginal Tablet ☐ Nasal Gel ☐ Pellet (Implant)

List all previous HRT Dosages, Frequency, and Forms/Routes of Administrations

1- Do you have known allergies/sensitivities to:

☐ Adhesives ☐ Benzyl Alcohol ☐ Latex ☐ Lidocaine ☐ Topical Anesthetics

2- Have you ever had an allergic reaction to sutures/stitches? ☐ Yes ☐ No

3- Have you ever had an adverse reaction or significant side effects to HRT in the past? ☐ Yes ☐ No

If you marked an allergy above in line item 1 or marked yes to items 2-3 above, please explain below:

Do you have any surgical implants, screws, pins in treatment area(s)? ☐ Yes ☐ No

Do you currently take/use any medications that may cause increased risk of bleeding or delayed healing?

☐ Yes ☐ No

If yes, please check all that apply: ☐ Anti-Platelets ☐ Blood Thinners ☐ Corticosteroids ☐ NSAIDS

Female Medical History:

Are you currently: ☐ Pregnant ☐ Trying to conceive ☐ Breastfeeding ☐ Peri-menopausal

Current Birth Control:
☐ Abstinence ☐ Depo Provera ☐ Mirena/Copper ☐ Nexplanon ☐ Tubal Ligation
☐ Birth Control Pill ☐ Hysterectomy ☐ Menopause ☐ NuvaRing ☐ Vasectomy

☐ Other (Please Explain):

Date of Last Menses: **Pregnancies:** **Live Births:**

Pap Results/Date: **Mammogram Results/Date:**

Are you experiencing or have you ever been diagnosed with any of the following:

☐ Blood Clots ☐ Breast Cancer (Family) ☐ Endometrial Cancer ☐ Vaginal Bleeding (Abnormal)
☐ Breast Cancer (Self) ☐ Ductal Hyperplasia (Breast) ☐ Uterine Fibroids

General Medical History:

Date of last blood work: **Date of last colorguard or colonoscopy:**

Describe any abnormal results:

Have you ever been diagnosed with or currently have:

- ☐ Angina/Chest Pain
- ☐ Arthritis/Rheumatism
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Blood Clotting Disorder
- ☐ Cancer
- ☐ Chemical Dependence
- ☐ Congestive Heart Failure
- ☐ Diabetes
- ☐ Emotional Disorder
- ☐ Gallbladder Disease
- ☐ Genitourinary Disorder
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Immune Deficiency
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver Disease
- ☐ Muscle Disorder
- ☐ Neurological Disorder
- ☐ Orthopedic Disorder
- ☐ Poor Wound Healing
- ☐ Renal Insufficiency
- ☐ Stroke/TIAs
- ☐ Thyroid Issues

Please explain any items you marked above:

Digestion / Elimination: Have you recently experienced any of these symptoms?

- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Daily BM
- ☐ IBS
- ☐ Other (Please Explain):

Do you have any other medical issues not listed above? ☐ Yes ☐ No

If yes, please describe issue here:

Do you consume alcohol? ☐ Yes ☐ No

If yes, please list number of drinks you consume per week:

Do you smoke? ☐ Yes ☐ No

If yes, please describe how often and how much you smoke:

If there is anything else you'd like to share, please let us know here:

Patient Name: _____ **DOB:** _____ **Date:** _____

Medication Record

Please list medications, over the counter drugs, and herbal supplements you are currently taking. Please include any prescription topical creams and hormone replacement therapy medications/implants.

Medication or Supplement	*Frequency*	*Dose*	*Purpose/Prescribed For*

Allergies & Sensitivities

Do you have any allergies or sensitivities to foods, medications, implants, etc? ☐ Yes ☐ No

If yes, please list all allergens and how you react to them:

_____

_____

Surgical History

Have you been hospitalized or received acute medical care, including surgeries, in the past year? ☐ Yes ☐ No

If yes, please describe here: _____

Primary Care Physician: _____ **Phone:** _____

List surgical procedures you have had with approximate dates:

_____

_____

I affirm the information I have provided regarding my health history, medication record, and prior surgeries and aesthetic treatments is accurate to the best of my knowledge. I acknowledge that Optimal Health Montana staff is not responsible for any errors that may occur as a result of any omissions or incorrect information on this form. I acknowledge that OHM, Missy Miculka, is not a doctor, nor is she offering medical advice, I am responsible for my choices.

Patient Name (Print) **Patient Signature** **Date**