



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: \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

**How did you hear about us?**  Social Media: \_\_\_\_\_  Referral: \_\_\_\_\_  
 Internet Search  Other: \_\_\_\_\_

**What are your chief complaints and/or reasons for seeking HRT? Please check all that apply:**

- |  |   |  |  |  |
|--|---|--|--|--|
| <input type="checkbox"/> Acne                | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Hair Thinning/Loss    | <input type="checkbox"/> Low Energy    | <input type="checkbox"/> Sore Muscles/Joints |
| <input type="checkbox"/> Bone Density Loss   | <input type="checkbox"/> Dull/Dry Skin            | <input type="checkbox"/> Heat/Cold Intolerance | <input type="checkbox"/> Low Mood      | <input type="checkbox"/> Urogenital Atrophy  |
| <input type="checkbox"/> Brain Fog           | <input type="checkbox"/> Dry Hair/Brittle Nails   | <input type="checkbox"/> Headache/Migraine     | <input type="checkbox"/> Memory Issues | <input type="checkbox"/> Vaginal Dryness     |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Fat Deposits             | <input type="checkbox"/> Increased Stress      | <input type="checkbox"/> Mood Swings   | <input type="checkbox"/> Water Retention     |
| <input type="checkbox"/> Decreased Libido    | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Increased Wrinkles    | <input type="checkbox"/> Muscle Loss   | <input type="checkbox"/> Weight Gain         |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Fibromyalgia             | <input type="checkbox"/> Joint Pain/Swelling   | <input type="checkbox"/> Night Sweats  | <input type="checkbox"/> Weight Loss         |
| <input type="checkbox"/> Difficulty Sleeping |   | <input type="checkbox"/> Saggy/Loose Skin      |  |  |

**Are there any other reasons you are seeking HRT not listed above? Please describe below:**

\_\_\_\_\_

\_\_\_\_\_

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

- |   |   |                                       |                                       |
|---|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Estrogen         | <input type="checkbox"/> Human Growth Hormone | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Testosterone |
| <input type="checkbox"/> Estrogen Blocker | <input type="checkbox"/> Oestrogen            | <input type="checkbox"/> Progestin    | <input type="checkbox"/> Tibolone     |

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

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Buccal Tablet    | <input type="checkbox"/> Injection (IM)      | <input type="checkbox"/> Intravaginal Ring   | <input type="checkbox"/> Oral Tablet      |
| <input type="checkbox"/> Creams (Topical) | <input type="checkbox"/> Intravaginal Cream  | <input type="checkbox"/> Intrauterine Device | <input type="checkbox"/> Patch (Topical)  |
| <input type="checkbox"/> Gels (Topical)   | <input type="checkbox"/> Intravaginal Tablet | <input type="checkbox"/> Nasal Gel           | <input type="checkbox"/> 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

**Control:**  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 cologuard or colonoscopy:** \_\_\_\_\_

**Describe any abnormal results:** \_\_\_\_\_

**Have you ever been diagnosed with or currently have:**

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

**Please explain any items you marked above:**

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

If yes, please describe issue here: \_\_\_\_\_

**Do you consume alcohol?**  Yes  No

**Do you smoke?**  Yes  No

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

<b>Medication or Supplement</b>	<b>Frequency</b>	<b>Dose</b>	<b>Purpose/Prescribed For</b>

**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:

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**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 \_\_\_\_\_