PhySlim
Physician Guided Weight Loss & Wellness-

Bioidentical Hormone Replacement Candidate Questionnaire

Name: _____ **Date of Birth:** _____

Personal Medical History:

Last Menstrual Period Date: _____

Hysterectomy: Yes _____ Complete Partial Date: _____ No _____

Last Gynecologic Exam Date: _____

Last Pap Smear: Date: _____ Normal? Yes _____ No _____

If no, please explain:

_____

_____

Breast Cancer: Yes _____ No _____

Cervical/Uterine/Ovarian Cancer: Yes _____ No _____

Hormone Replacement Therapy in the past: Yes _____ No _____

If yes, please explain:

_____

Please list any additional medical problems/conditions/diagnoses:

_____

_____

Family Medical History:

Breast Cancer: No _____ Yes _____ Who _____

Cervical/Uterine/Ovarian Cancer: Yes _____ No _____ Who _____

Other cancers/medical problems:

_____

_____

Medications: Please list any medications including over the counter medicines and any vitamins, herbs, or supplements: _____

_____

Please list any surgeries: _____

_____

Please check all that apply:

___ Nervousness/Anxiety

___ Irritability/Aggressiveness

___ Swollen/tender breasts during period

___ Facial wrinkles

___ Increased belly fat

___ Decreased sexual drive

___ Hot flashes

___ Dry skin

___ Dry eyes

___ Cold sensitivity/intolerance

___ Facial/Eye puffiness in the morning

___ Difficulty getting out of bed in the morning

___ Joint stiffness in the morning

___ Wrinkling of the upper lip area

___ Often feel depressed

___ Irregular menstrual cycles

___ Difficulty sleeping

___ Heavy periods

___ Decreased muscle tone

___ Decreased muscle tone

___ Fatigue/Tire easily

___ Decreased self-confidence

___ Thinning hair

___ Dry hair

___ Decreased under/pubic hair

___ Hands/Feet often cold

___ Gain weight easily

___ Constipation

___ Losing hair on top of head

___ Droopy breasts

___ Heavy menstrual flow