



RENOVO Female Hormone Questionnaire

Name _____

Age _____

Number of Pregnancies _____ Births _____ Living Children _____

When was your last menstrual period? _____ Are you still having menstrual periods? _____

Have you had any bleeding recently? _____ Have you had a hysterectomy? _____

Are you taking any hormones? If so, what? _____

Medical History Please report any medical conditions that you have.

Medications that you are currently taking?

Do you have any Allergies to medicines? Latex Allergies? Tape Allergies? _____ If so, what? _____

Surgical Procedures Please report any surgical procedures you have had and when.

Family History Please report any significant medical conditions, including cancers that affect your family?

When was your last mammogram? And where did you have it?

When did you have your most recent annual/pap examination? And where did you have it? What doctor did you see?

Please answer the following questions as accurately as you can. Thank you.

	NEVER	MILD	MODERATE	SEVERE
Mood changes/ Irritability	_____	_____	_____	_____
Tension	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Memory Loss	_____	_____	_____	_____
Mental confusion	_____	_____	_____	_____
Nervousness	_____	_____	_____	_____
Migraine/severe headaches	_____	_____	_____	_____
Decreased sex drive/libido	_____	_____	_____	_____
Difficult to climax sexually	_____	_____	_____	_____
Bloating	_____	_____	_____	_____
Weight gain	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Vaginal dryness	_____	_____	_____	_____
Breast tenderness	_____	_____	_____	_____
Hot flashes	_____	_____	_____	_____
Night sweats	_____	_____	_____	_____
Sleep disruption/Insomnia	_____	_____	_____	_____
Bladder symptoms	_____	_____	_____	_____
Joint pain	_____	_____	_____	_____
Hair loss	_____	_____	_____	_____