Rebecca Weiss, D.O. phone 602.266.8144 fax 602.266.9670 drweiss@paradisemedspa.com



Kristine Sarna, M.D. 602.266.8144 phone 602.266.9670 fax drsarna@paradisewellness.com

NATURAL HORMONE THERAPY QUESTIONNAIRE

1. Are you taking natural hormone therapies now? If so, which products and for how many years?		Yes	No
2. Did you have any bothersome effects from your therapy? If so, what were they?		Yes	No
3. Have you ever uses oral contraceptives? If "yes", any problems?		Yes	No
4. Have you had a hysterectomy? If yes, when?		Yes	No
Did they remove the ovaries?		Yes	No
5. Have you had a tubal ligation?		Yes	No
6. Do you have irregular bleeding? If so, please describe.		Yes	No
7. Do you have a family history of:			
Uterine Cancer	Ovarian Cancer	Stroke	
Heart Attack	Osteoporosis	Blood Clots	
Liver Problems	Thyroid Disease	Diabetes	
High cholesterol	High Blood Pressure		
8. Has your mother, aunts on your mother's side, or sisters had Breast Cancer? Yes No Please specify who and at what age they were diagnosed.			
When was the date of your n	nost recent:		
Mammogram	Pap Smear	Dexa Scan	
10. What was your most recent lab values:			
		HDL	
	If so, which products and for Did you have any bothersom If so, what were they? Have you ever uses oral cont If "yes", any problems? Have you had a hysterectom If yes, when? Did they remove the ovaries Have you had a tubal ligation Do you have irregular bleeding If so, please describe Do you have a family history Uterine Cancer Heart Attack Liver Problems High cholesterol Has your mother, aunts on you please specify who and at who was the date of your mammogram What was your most recent I Total cholesterol	If so, which products and for how many years?	If so, which products and for how many years? Did you have any bothersome effects from your therapy? Yes If so, what were they? Have you ever uses oral contraceptives? Yes If "yes", any problems? Have you had a hysterectomy? Yes If yes, when? Did they remove the ovaries? Yes Have you had a tubal ligation? Yes Use you have irregular bleeding? Yes If so, please describe. Do you have a family history of: Uterine Cancer Ovarian Cancer Stroke Heart Attack Osteoporosis Blood Clots Liver Problems Thyroid Disease Diabetes High cholesterol High Blood Pressure Has your mother, aunts on your mother's side, or sisters had Breast Cancer Please specify who and at what age they were diagnosed. When was the date of your most recent: Mammogram Pap Smear Dexa Scan What was your most recent lab values: Total cholesterol Triglycerides HDL