HORMONE REPLACEMENT THERAPY HISTORY

Name: _____Age: _____

Height: _____ Weight: _____

Race: (please circle)

American Indian Asian Black Hispanic Caucasian

Number of Pregnancies	**_____**	
Number of Live Births	**_____**	
Number of Abortions/Miscarriages	**_____**	
History of Renal Disease	**yes**	**no**
Active Liver Disease	**yes**	**no**
Hysterectomy	**yes**	**no**
History of Cervical Cancer	**yes**	**no**
History of Ovarian Cancer	**yes**	**no**
Fibrocystic Breast Disease	**yes**	**no**
History of Breast Cancer	**yes**	**no**
Acne	**yes**	**no**
Facial Hair	**yes**	**no**
Hair Loss	**yes**	**no**
History of PCOS (Poly-cystic ovarian syndrome)	**yes**	**no**
History of Heavy Menses/Fibroids	**yes**	**no**
History of Metabolic Syndrome	**yes**	**no**
Premenopausal	**yes**	**no**
Menstrual Migraines	**yes**	**no**
Persistent Breast Pain	**yes**	**no**
Fluid Retention	**yes**	**no**
Headaches	**yes**	**no**
Are you currently on any HRT meds	**yes**	**no**

If yes, please list NAME and DOSAGE

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