Female BHRT Medical History Form

MURFREESBORO BIO RENEW & IV INFUSION CLINIC

Patient Info

Name _____
Last Middle First

Address _____ Height _____ Weight _____ Sex M / F

City _____ State _____ Zip _____ DOB _____ Age _____ Marital Status _____

Phone _____ Email _____ Occupation _____

Allergies:	Medications, OTC, Vitamins:

Medical Conditions/Diseases (Please check all that apply)

_____ Heart disease - Type: _____	_____ Lung disease (ex: asthma, COPD)	_____ Cancer - Type: _____
_____ High cholesterol or lipids	_____ Ulcers	_____ Diabetes
_____ High blood pressure	_____ Arthritis or joint problems	_____ Depression
_____ Thyroid disease	_____ Headaches / migraines	_____ Endometriosis
_____ Liver Disease	_____ Persistent urinary tract infections	_____ Fibrocystic breast
_____ Osteoporosis	_____ Abnormal vaginal bleeding	_____ Stroke
_____ Uterine Fibrosis/Ovarian Cysts	_____ Blood clots (i.e. DVT, PE)	_____ Other - Please list: _____

Do you have a history or family history of any of the following?

	Yes	No	Family Member(s)
Uterine Cancer	☐	☐	
Ovarian Cancer	☐	☐	
Breast Cancer	☐	☐	

Have you had any of the following procedures / exams?

	Yes	No	Date
Hysterectomy (uterus)	☐	☐	
Oophorectomy (ovaries)	☐	☐	
Tubal Ligation	☐	☐	
Sexually transmitted infections	☐	☐	

Have you had any of the following?

	Yes	No	How many?
Pregnancies	☐	☐	
Miscarriage	☐	☐	
Children	☐	☐	

Do you use any of the following?

	Yes	No	If yes, how often and how much
Alcohol	☐	☐	
Tobacco	☐	☐	
Caffeine	☐	☐	
Soy	☐	☐	
Other	☐	☐	

Have you had any of the following exams?

	Yes	No	Date / Result
Mammography	☐	☐	
PAP Smear	☐	☐	
Pelvic ultrasound	☐	☐	
Bone density scan	☐	☐	

Please answer the following questions

	Yes	No	How many?
Do you plan to have more children	☐	☐	
Are you currently breastfeeding?	☐	☐	
Are you currently pregnant?	☐	☐	
Are you currently sexually active?	☐	☐	

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Female BHRT Medical History Form

Name _____
Last Middle First

Please answer the following questions

Have you ever used contraceptives? ☐Yes ☐No

If yes, list medications, dose, directions, and duration of treatment _____

Did you have any problems? If yes, please explain. _____

Have you ever used hormone replacement therapy? ☐Yes ☐No

If yes, list medications, dose, directions, and duration of treatment _____

Did you have any problems? If yes, please explain. _____

Do you exercise? ☐Yes ☐No

If yes, please describe your routine. _____

Do you currently follow a special diet? ☐Yes ☐No

If yes, please explain. _____

Please answer according to if you are currently cycling or when you were cycling.

Date of last period. _____

How many days does your period last? _____

Do you have heavy cycles? If yes, please explain. ☐Yes ☐No _____

Do you have regular cycles? If no, please explain. ☐Yes ☐No _____

How many days is your menstrual cycle? _____

What are your top three goals for starting Hormone Replacement Therapy?

1. _____

2. _____

3. _____

Patient Signature _____ Date _____

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