Dr. Gail M. Gagnon

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Medical History and Symptom Questionnaire for Females

Demographics

Date completed:	**Last Name:**	**First Name:**	**Middle Initial:**
Address:			
City:		**State:**	**Zip Code:**
Gender:	**Date of Birth:**		**Age:**
Height (Feet/Inches):	**Weight (Pounds):**	**Weight which you felt your best:**	

Communication

Phone (preferred):
Phone (secondary):
Fax:
E-Mail:

Emergency Contact

Name:	
Telephone Number:	**Relationship:**

Physician Information (Dr. Gagnon is a consultant, not a primary physician)

Primary Care Physician Name:
Telephone Number:
Address:
Specialist Physician/Name:
Telephone Number:
Address:

Chief Goal

What signs/symptoms do you hope to resolve with BHRT?

Energy Level

Please rank the following from 0 ("I'm so tired, I can't get out of bed") to 10 ("I feel like I'm 20 years old today"):		
Upon arising in the morning	**Time:**	**Ranking:**
At noon		**Ranking:**
Mid-afternoon	**Time:**	**Ranking:**
Dinner	**Time:**	**Ranking:**
Bedtime	**Time:**	**Ranking:**

Sleep Pattern

How long does it take you to fall asleep?
How many hours do you sleep before you awake for any reason?
How long does it take you to fall back to sleep?
Do you awake in the morning feeling tired?
Do you snore?
Do you have frequent pauses in breathing while you sleep (you stop for 10 seconds or longer)?
Do you wake up with a headache?
Is your collar size larger than 17?

Past Medical History

Have you ever had, or are you currently being treated for (please include date of initial diagnosis):
Cancer:
Heart Disease:
High Blood Pressure:
Blood Clotting Problems:
High Cholesterol:
Diabetes:
Thyroid Disease:
Arthritis/Joint Pain:
Depression:
Osteopenia/Osteoporosis:
Ulcers/GERD:
Lung Condition:
Obesity:
Other/Please List:

Over the Counter Products

Pain/Cough-Cold/Sleep Aids/Stomach Problems:

Prescription Medications

Hormones – both previous and current (year start and stop):

Non-Hormone:

Nutritional Supplements/Purpose

Allergies

Antibiotics/Prescription/Environmental/Food. Describe reaction.

Social History

Do you have a lot of stress in your life?
Do you use tobacco? (frequency of use per day)
Do you drink alcohol? (type and amount per day)
Do you drink caffeine? (source and amount per day)
Are you employed? Describe occupation/stressful?/physically demanding?
Are you retired? Stressful?
Marital Status (Single/Married/Divorced/Partnered)
Do you have children? (Ages)
Do your children live with you?

Family History (CA = Cancer)

(Indicate family relationship and age of disease – Mother/Father/Grandparents/Siblings – Please include age of death if applicable)

Breast CA/age:
Prostate CA/age:
Uterine CA/age:
Ovarian CA/age:
Colon CA/age:
Lung CA/age:
Heart Disease/Stroke:
High Blood Pressure:
High Cholesterol:
Diabetes:
Thyroid:
Osteopenia/Osteoporosis:
Alzheimer Disease/Dementia:

Previous Tests

Mammogram:	**Date:**	**Results:**
Pap Smear:	**Date:**	**Results:**
Uterine Ultrasound:	**Date:**	**Results:**
Bone Mineral Density:	**Date:**	**Results:**

Exercise History

Type of exercise/duration/number of times per week:

At what age did you have your first period (Menarche)?
Have you ever had Premenstrual Syndrome (PMS)?
Have you ever used oral contraceptives/date?
Are you still menstruating/last menses?
How many pregnancies/children/miscarriages?
Have you had a tubal ligation/date?
Have you had a hysterectomy/why/date?
Have your ovaries been removed/why/date?
Have you had/currently have Uterine Fibroids/Endometriosis/Ovarian Cysts?

Do you have additional history you would like the doctor to know?

Do you have any specific questions regarding BHRT?

How did you hear about me?