EXO-REGEN WELLNESS

HORMONE REPLACEMENT THERAPY QUESTIONAIRE

NAME OF PATIENT: _____ **DATE:** _____

PREVIOUS EXPERIENCE WITH HORMONE

REPLACEMNT THERAPY (BHRT, HRT, TRT)

Discuss any previous Hormone Replacement Therapy:

Start date: _____ **What did you try?** _____

What did you like? _____

What did you dislike? _____

Reason for discontinuing: _____

Discuss any Hormone Replacement Therapy:

Start date of therapy: _____ **What did you use?** _____

What do you like? _____

What do you dislike? _____

Are you currently active? **YES / NO**

Are you satisfied with your current sexual activity? **YES / NO**

What would you like to change about your sexual activity? _____

Have you previously taken oral contraceptives? **YES / NO**

Name: _____

How long: _____

Issues: _____

PESONAL DIET CONSIDERATIONS

How often do you consume the following items?

	DAILY	WEEKLY	MOTHLY	NEVER
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Spicy Foods	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

List your food intake for the last three days:

BREAKFAST	LUNCH	SNACK	DINNER