HORMONE SYMPTOM QUESTIONARE

SYMPTOM	*Circle Level of Severity {O for no symptoms -10 for severe)*										
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10
Foggy Thinking	0	1	2	3	4	5	6	7	8	9	10
Fatigue ·	0	1	2	3	4	5	6	7	8	9	10
Low Libido	0	1	2	3	4	5	6	7	8	9	10
Poor Sleep	0	1	2	3	4	5	6	7	8	9	10
Irritability	0	1	2	3	4	5	6	7	8	9	10
Mood Swings	0	1	2	3	4	5	6	7	8	9	10
Depression	0	1	2	3	4	5	6	7	8	9	10
Anxiety	0	1	2	3	4	5	6	7	8	9	10
Panic Attacks	0	1	2	3	4	5	6	7	8	9	10
Tearful	0	1	2	3	4	5	6	7	8	9	10
Weight. Gain	0	1	2	3	4	5	6	7	8	9	10
Water Retention	0	1	2	3	4	5	6	7	8	9	10
Difficultly Losing Weight	0	1	2	3	4	5	6	7	8	9	10
Sugar Cravings	0	1	2	3	4	5	6	7	8	9	10
Hair Loss	0	1	2	3	4	5	6	7	8	9	10
Increased Facial Hair	0	1	2	3	4	5	6	7	8	9	10
Joint Pain	0	1	2	3	4	5	6	7	8	9	10
Dry Skin	0	1	2	3	4	5	6	7	8	9	10
Oily Skin	0	1	2	3	4	5	6	7	8	9	10
Urinary Incontinence	0	1	2	3	4	5	6	7	8	9	10
WOMEN ONLY:											
Vaginal Dryness	0	1	2	3	4	5	6	7	8	9	10
Hot Flashes	0	1	2	3	4	5	6	7	8	9	10
Night Sweats	0	1	2	3	4	5	6	7	8	9	10
Breakthrough Bleeding	0	1	2	3	4	5	6	7	8	9	10

Patient Name: _____ DOB: _____ Date: _____