TOTAL NUTRITION AND THERAPEUTICS

Hormone Symptom Assessment

Patient Name: _____ **Date:** _____

Which of the following symptoms apply to you at this time? Please make the appropriate box for each symptom. For symptoms that do not apply, please mark 'None'.

	None	Mild	Moderate	Severe	Very Severe
Score:	0	1	2	3	4
1. Hot flashes , sweating (episodes of sweating)	☐	☐	☐	☐	☐
2. Heart discomfort (unusual awareness of heart beat, heart skip-ping, heart racing, tightness	☐	☐	☐	☐	☐
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early	☐	☐	☐	☐	☐
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. Irritability (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. Anxiety (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. Bladder problems (difficulty urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse.	☐	☐	☐	☐	☐
11. Joint and muscular discomfort (pain in joints, rheumatoid complaints.	☐	☐	☐	☐	☐

Last Pap: Date _____ Normal/Abnormal: _____

Last Mammogram: Date: _____ Normal/Abnormal: _____

Family History of Breast Cancer? ☐ Yes ☐ No Last Menstrual Period: Date: _____

1st Degree Relative ☐ Yes ☐ No Cycle every ☐ 28 Days or ☐ Irregular

Osteoporosis/Osteopenia ☐ Yes ☐ No Flow: ☐ Heavy ☐ Medium ☐ Light

Have you been on Hormones in the past? ☐ Yes ☐ No Type: _____ Length of Treatment: _____

Any history of Cancer? Type: _____ Treatments: _____ Any Complications: _____