



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
<i>Score:</i>	0	1	2	3	4
1. Hot flashes , sweating (episodes of sweating)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through, waking up early)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Irritability (feeling nervous, inner tension, feeling aggressive)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Anxiety (inner restlessness, feeling panicky)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Bladder problems (difficulty urinating, increased need to urinate, bladder incontinence)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Joint and muscular discomfort (pain in joints, rheumatoid complaints.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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: _____