

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)	<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: