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 skipping, 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
1st Degree Relative Yes/No

Last Menstrual Period: Date: ________________
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: ________________