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HORMONE SYMPTOM QUESTIONNAIRE

Name_____

Date of Birth_____

Date this history form completed:_____

For all of the following symptoms, please rate on a 0-4 scale how severe the problem is for you. If you are not having any problem with that symptom, please place a 0, if the problem is severe, please use a 4.

___hot flashes	___nightsweats	___vaginal dryness
___foggy thinking	___memory lapse	___tearful easily but not sad
___bloating and gas	___constipation	___sleep disturbance
___aches and pains	___fibromyalgia	___morning fatigue
___allergies	___sensitivity to chemicals	___stress
___sugar craving	___chronic sinusitis	___weight gain – waist
___loss scalp hair	___increased facial/body hair	___acne
___nervous/anxious	___tender breasts	___bleeding changes
___urine leak with cough	___depressed feeling	___headaches/migraines
___evening fatigue	___cold body temperature	___low sex drive
___mood swings	___irritability	___urine urgency/frequency
___rapid aging/skin changes	___diarrhea/bowel irritability	___irregular periods
___abdominal discomfort	___high blood pressure	___water retention
___fibrocystic breasts	___weight gain – hips	___fecal urgency
___PMS	___high cholesterol	___swelling/puffy eyes/face
___slow pulse	___hair dry/brittle	___nails brittle/breaking
___thinning skin	___rapid heart rate	___bad breath
___low exercise tolerance	___low blood pressure	
___stool that floats or contains food	___rectal or vaginal itching	

What are your five worst symptoms from the above list?

For each of them, how long have they been a problem?

Did each of those problems start suddenly or gradually?

What have you tried to relieve these symptoms? What makes them worse?

Is there a cyclic component, or a daily rhythmic component to any of the symptoms?

How do you feel when you wake up?

How well do you sleep?

How is your energy level?

Have you had a change in weight?