

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please indicate the symptoms you are experiencing as; 0 (none), 1 (mild), 2 (moderate), 3 (severe).

For example, if you are moderately anxious you would indicate this by darkening the 2 next to 'anxious' e.g. 0 1 **2** 3 Anxious

ALL INDIVIDUALS

WOMEN ONLY

- 0  1  2  3 Difficulty Concentrating
- 0  1  2  3 Increased Forgetfulness
- 0  1  2  3 Foggy Thinking
- 0  1  2  3 Tearful
- 0  1  2  3 Depressed
- 0  1  2  3 Mood Swings
- 0  1  2  3 Fluid Retention / Bloating
- 0  1  2  3 Cold Extremities
- 0  1  2  3 Stress
- 0  1  2  3 Anxious
- 0  1  2  3 Irritable
- 0  1  2  3 Nervous
- 0  1  2  3 Decreased Mental Sharpness
- 0  1  2  3 Morning Fatigue
- 0  1  2  3 Afternoon Fatigue
- 0  1  2  3 Evening Fatigue

- 0  1  2  3 Excessive Worry
- 0  1  2  3 Difficulty Falling Asleep
- 0  1  2  3 Difficulty Staying Asleep
- 0  1  2  3 Decreased Stamina
- 0  1  2  3 Diminished Motivation
- 0  1  2  3 Fibromyalgia
- 0  1  2  3 Ringing in Ears
- 0  1  2  3 Allergies
- 0  1  2  3 Headaches/Migraines
- 0  1  2  3 Dizzy Spells
- 0  1  2  3 Sugar Cravings
- 0  1  2  3 Addictive Behavior
- 0  1  2  3 Poor Impulse Control
- 0  1  2  3 Obsessive Behavior (OCD)
- 0  1  2  3 Craving Food, Alcohol, Tobacco, or Other

- 0  1  2  3 Constipation
- 0  1  2  3 Goiter
- 0  1  2  3 Cold Body Temperature
- 0  1  2  3 Hoarseness
- 0  1  2  3 Hair Dry or Brittle
- 0  1  2  3 Nails Breaking or Brittle
- 0  1  2  3 Slow Pulse Rate
- 0  1  2  3 Rapid Heartbeat
- 0  1  2  3 Heart Fluttering/Palpitations
- 0  1  2  3 Incontinence
- 0  1  2  3 Hot Flashes
- 0  1  2  3 Night Sweats
- 0  1  2  3 Infertility Problems
- 0  1  2  3 Acne
- 0  1  2  3 Scalp Hair Loss
- 0  1  2  3 Weight Gain-Hips

- 0  1  2  3 Weight Gain-Waist
- 0  1  2  3 High Cholesterol
- 0  1  2  3 Elevated Triglycerides
- 0  1  2  3 Decreased Libido
- 0  1  2  3 Decreased Muscle Size
- 0  1  2  3 Decreased Flexibility
- 0  1  2  3 Burned Out Feeling
- 0  1  2  3 Sore Muscles
- 0  1  2  3 Increased Joint Pain
- 0  1  2  3 Neck or Back Pain
- 0  1  2  3 Bone Loss
- 0  1  2  3 Thinning Skin
- 0  1  2  3 Rapid Aging
- 0  1  2  3 Aches and Pains
- 0  1  2  3 IBS
- Height (inches) \_\_\_\_\_
- Weight (lbs) \_\_\_\_\_

- 0  1  2  3 Vaginal Dryness
- 0  1  2  3 Irregular Periods
- 0  1  2  3 Uterine Fibroids
- 0  1  2  3 Tender Breasts
- 0  1  2  3 Fibrocystic Breasts
- 0  1  2  3 Increased Facial / Body Hair

Last Menses \_\_\_/\_\_\_/\_\_\_

MEN ONLY

- 0  1  2  3 Decreased Urine Flow
- 0  1  2  3 Increased Urinary Urge
- 0  1  2  3 Prostate Problems
- 0  1  2  3 Decreased Erections

Personal/Family History of: Breast, Uterine, or Ovarian Cancer

Additional Comments: \_\_\_\_\_

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