

Hormone Symptom Questionnaire

Patient Name: _____ DOB: _____ Date: _____

 Please circle one of the following categories below to let us know how you are feeling at today's appointment:
 Current status- What are your CURRENT Symptoms?

0 means you have no symptoms of this type at all 1 means you have very mild symptoms of this type, 5 would be moderate symptoms and 10 would mean you have severe symptoms of this type.

	Low.....	Moderate.....	Severe.....	Comments, if any								
(P)												
Sleep Disturbances	0	1	2	3	4	5	6	7	8	9	10	_____
Depression	0	1	2	3	4	5	6	7	8	9	10	_____
Irritability	0	1	2	3	4	5	6	7	8	9	10	_____
Anxiety	0	1	2	3	4	5	6	7	8	9	10	_____
Mood Swings	0	1	2	3	4	5	6	7	8	9	10	_____
Migraine Headaches	0	1	2	3	4	5	6	7	8	9	10	_____
Palpitations	0	1	2	3	4	5	6	7	8	9	10	_____
(E)												
Night sweats	0	1	2	3	4	5	6	7	8	9	10	_____
Hot flashes	0	1	2	3	4	5	6	7	8	9	10	_____
Dry Skin	0	1	2	3	4	5	6	7	8	9	10	_____
Restless Leg Syndrome	0	1	2	3	4	5	6	7	8	9	10	_____
Painful Intercourse (Women)	0	1	2	3	4	5	6	7	8	9	10	_____
Hair Loss (Women)	0	1	2	3	4	5	6	7	8	9	10	_____
(T)												
Fatigue	0	1	2	3	4	5	6	7	8	9	10	_____
Low Sex Drive	0	1	2	3	4	5	6	7	8	9	10	_____
Poor Focus	0	1	2	3	4	5	6	7	8	9	10	_____
Body-Joint Pains	0	1	2	3	4	5	6	7	8	9	10	_____
Memory Lapses	0	1	2	3	4	5	6	7	8	9	10	_____
Low Exercise Tolerance	0	1	2	3	4	5	6	7	8	9	10	_____
Loss of muscle Tone	0	1	2	3	4	5	6	7	8	9	10	_____
Erectile Dysfunction (Men)	0	1	2	3	4	5	6	7	8	9	10	_____

Are you currently fasting? (on day of lab draw) Yes / No

Do you have a regular menstrual cycle? Yes / No If yes, date of last cycle: _____

Have you taken any medication or supplements this morning? Yes / No

If yes, _____

Comments: _____

Patient Signature: _____ Date: _____