LBC Woman's Health & Wellness

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HORMONE SYMPTOM CHECK LIST

NAME: _____ Age: _____ Date: _____

In the past week I have experienced? 0 = no 1 = some 2 = often Is this a problem for you?

Hot flashes (night sweats … kicking covers off feet)	0	1	2	Y	N
Sleep disturbance- frequent awakening or mind racing	0	1	2	Y	N
Fatigue, weakness	0	1	2	Y	N
Memory Loss, foggy thinking	0	1	2	Y	N
Depression, Irritability, Mood Swings, Tension	0	1	2	Y	N
Easily tearful	0	1	2	Y	N
Wanting to be left alone … isolating behavior	0	1	2	Y	N
Anxiety, panic that comes and goes	0	1	2	Y	N
Heart palpitations, lightheaded or dizzy (circle those that apply)	0	1	2	Y	N
Chest pressure or pain, shortness of breath	0	1	2	Y	N
Lost days from work	0	1	2	Y	N
Bloating, flatulence (gas)	0	1	2	Y	N
Muscle or joint aches and pains	0	1	2	Y	N
Hair loss, Dry skin, nose bleeds, facial hair (circle those that apply)	0	1	2	Y	N
Skin 'crawling', sensitivity to touch, numbness	0	1	2	Y	N
Migraines (more frequent)	0	1	2	Y	N
Weight gain (especially mid body)	0	1	2	Y	N
Occasional extreme breast tenderness	0	1	2	Y	N
Vaginal dryness, itching, burning	0	1	2	Y	N
Pain with intercourse	0	1	2	Y	N
Lessened sexual desire, drive, activity	0	1	2	Y	N
Difficulty achieving orgasm	0	1	2	Y	N
Frequent vaginal / urinary tract infections	0	1	2	Y	N
Leaking urine with cough, sneeze, laugh, exercise	0	1	2	Y	N
Leaking urine with strong sudden urge	0	1	2	Y	N

Which of the above is the most problematic for you?

_____

_____

Other symptoms:

_____

_____

_____