Hormone Replacement Therapy Female Symptom Sheet

Name: _____ **Date:** _____ **Age:** _____

DOB: _____ **BP:** _____ **WT:** _____

Hysterectomy: Yes ☐ No ☐ Progesterone: Yes ☐ No ☐ LMP: / /

Family History of Cancer: Yes ( ) No ( ) Last Pap: Last Mamo:

Symptom	Absent	Mild	Moderate	Severe
Breast Tenderness				
Weight Gain				
Irregular Menses				
Hot Flashes				
Night Sweats				
Dry Skin & Hair				
Hair Loss				
Headaches				
Irritability				
Anxiety				
Depression				
Mood Swings				
Brain Fog				
Memory Loss				
Sleep Disturbances/Insomnia				
Decreased Sex Drive				
Harder to reach climax				
Joint pain				
Fatigue				
Fluid Retention				
Vaginal Dryness				

Doctors Note: _____