FEMALE HRT SYMPTOM QUESTIONNAIRE

Patient Name: _____ DOB: _____ Date: _____

In the past 2 weeks, please indicate if you have had any of these symptoms and rate the symptoms from 1 to 5. 1 - not too much of a problem - 5 - very much a problem. Use the blank space to explain or comment.

Anxiety/irritability	1	2	3	4	5	N/A	
Tearful	1	2	3	4	5	N/A	
Sleep disturbance/insomnia	1	2	3	4	5	N/A	
Mood Swings	1	2	3	4	5	N/A	
Breakthrough Bleeding	1	2	3	4	5	N/A	
Decreased concentration	1	2	3	4	5	N/A	
Brain fog or Memory loss	1	2	3	4	5	N/A	
Feeling overwhelmed	1	2	3	4	5	N/A	
Night sweats/hot flashes	1	2	3	4	5	N/A	
Fatigue	1	2	3	4	5	N/A	
Vaginal dryness	1	2	3	4	5	N/A	
Breast tenderness	1	2	3	4	5	N/A	
Heavy Periods	1	2	3	4	5	N/A	
Depression Symptoms	1	2	3	4	5	N/A	
Urinary Incontinence	1	2	3	4	5	N/A	
Swelling in hands/feet	1	2	3	4	5	N/A	
Hot flashes during the day	1	2	3	4	5	N/A	
Muscle gain/loss	1	2	3	4	5	N/A	
Lack of Motivation	1	2	3	4	5	N/A	
Acne or Oily Skin	1	2	3	4	5	N/A	
Low Libido	1	2	3	4	5	N/A	
Poor recovery after workouts	1	2	3	4	5	N/A	
Craving Sweets or Salt	1	2	3	4	5	N/A	
Constipation or Diarrhea	1	2	3	4	5	N/A	
Hot/cold feet or hands	1	2	3	4	5	N/A	
Difficulty losing weight	1	2	3	4	5	N/A	
Hair Loss/thinning hair	1	2	3	4	5	N/A	
Pain during sex	1	2	3	4	5	N/A	