BHRT Checklist for Women

Name: _____ **Date:** _____

E-Mail: _____ **Phone:** _____

DOB: _____ **Age:** _____

Symptom (please check mark)	Never	Mild	Moderate	Severe
Depressive mood				
Fatigue				
Memory Loss				
Mental confusion				
Decreased sex drive/libido				
Sleep problems				
Mood changes/Irritability				
Tension				
Migraine/severe headaches				
Difficult to climax sexually				
Bloating				
Weight gain				
Breast tenderness				
Vaginal dryness				
Hot flashes				
Night sweats				
Dry and Wrinkled Skin				
Hair is Falling Out				
Cold all the time				
Swelling all over the body				
Joint pain				

Family History

	NO	YES
Heart Disease		
Diabetes		
Osteoporosis		
Alzheimer's Disease		
Breast Cancer		

Medical History: *Circle all that apply*

1) On Birth Control _____ 2)Still Menstrating 3) Experiencing Symptons
4) Currently Pregnant 5) On HRT (Type/Dose)_____
6) Hashimoto's Thyroiditis 7) Currently of Thyroid Medication (Type/Dose)
_____ 8) History of Breast Cancer 9) Hysterectomy 10)
Fibrocystic Breast Disease 11) PCOS 12) Currently On HRT _____
13) History of Uterine Fibroids or Endometria Polys 14) Epilespy 15) Smoker

Symptons: *Circle all that apply*

1)Acne 2)Breast Tenderness
3)Facial Hair 4) PreMenstrual Migraines Weight: _____ Ethnicity:
_____