Date____________________

Women's Health Hormone Self-Assessment

Name____ DOB_________________

Address:____

City:____ State:_________ Zip:________

Phone:____________________________ Email:____

Do you understand what Biologically Identical Hormone Replacement is? _________________________

Do you understand the risks involved due to your use of Biologically Identical Hormone Replacement such as myocardial infarction, breast cancer and heart disease? _____________________________________

What are your goals for Biologically Identical Hormone Replacement? ___________________________

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Date____________________

Is Biologically Identical Hormone Therapy Right for you?

Name____ DOB____________________

To what degree do you experience the following?

	None	Slightly	Moderate	Severe	Extreme
Difficulty Concentrating					
Can't Sleep (Insomnia)					
Depressed or Unhappy					
Anxious					
Headaches					
Moodiness/Emotional					
Painful or Swollen Breasts					
Weight gain/Bloating					
PMS					
	None	**Slightly**	**Moderate**	**Severe**	**Extreme**
Night Sweats					
Difficulty Remembering					
Brain Fog					
Hot Flashes					
Vaginal Dryness					
Dry Hair/Skin					
Incontinence					
Frequent Urinary Tract					
Inability to Reach Orgasm					
Painful Intercourse					
Lack of Sexual Desire					
Fatigue/Loss of Energy					