BHRT CHECKLIST FOR WOMEN

Name: _____ **Date:** _____

Email: _____

Symptom(s) (Please check)	**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	☐	☐