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Medford, OR 97504

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www.CompleteCare.net

Name: _____
DOB: _____
LMP: _____
Date of Service: _____

Female Hormonal Symptom Evaluation Sheet

	Absent	Mild	Moderate	Severe	Cyclic
Hot Flashes					
Night Sweats					
Vaginal Dryness					
Memory Loss					
Mental Fog					
Mood Swings					
Difficulty Sleeping/Insomnia					
Anxiety					
Breast Tenderness					
Bloating					
Headaches					
Weight Gain					
Food Cravings					
Depression					
Low Libido					
Low Sex Sensation					
Irritability					
Fatigue					
Hair Loss					
Dry Skin/Hair					
Acne/Oily skin					
Facial Hair					
Irregular Periods					
Other Symptoms					

What is your stress level? Range 1-10, 10 being the highest _____
What exercises do you do? _____
How many starches do you eat per day? _____
i.e. bread, crackers, rice, potatoes, cereal, etc.
How many servings of protein do you have per day? _____
i.e. poultry, meat, tofu, eggs, etc.
How many hours do you sleep at night/day? _____
Frequency of period, number of days apart? _____