|  |  |
| --- | --- |
| Name:  | D.O.B.  |
| Patient Information(Please Print) |
| SS#:  | Sex: **[ ]** M **[ ]** F | Marital Status: **[ ]** S **[ ]** M **[ ]** W **[ ]** D **[ ]** Sep |
| Address:  |
| City:  | State:  | ZIP:  |
| Spouse/Partner:       |  |
| Phone:  | Phone #2:  | Phone #3:  |
| Cell:  | Cell #2:  | Fax:  |
| Is it okay to leave Voice Mail?: [ ] Yes [ ]  No -       |
| Email:  |
| How do you prefer to be reached?       | Best time to contact you?       |
| Where did you first hear about us?       |
| **Primary Residence** |
| Address:  |
| City:  | State:  | ZIP:  |
| Phone:  | Cell:  | Fax:  |
| Email:  |
| **Secondary Residence** |
| Address:  |
| City:  | State:  | ZIP:  |
| Phone:  | Cell:  | Fax:  |
| Email:  |
| **Work** |
| Occupation:       | Employer:       |
| Address:       |
| City:       | State:       | ZIP:       |
| Phone:       | Cell:       | FAX:       |
| E-mail:       |
| **[ ]**  Complete insurance section only if checked **Insurance** |
| Person responsible for the bill:       | D.O.B.:       |
| Address (if different):       |
| Soc. Sec. #:       | Is patient covered by insurance? [ ] Yes [ ]  No |
| Primary insurance:       | Secondary insurance:       |
| Group no.:       | Policy no.:       | Co-payment:$       |
| Patient’s relationship to subscriber [ ]  Self [ ]  Spouse [ ]  Other:       |
| **Who do you wish us to contact in an emergency?** |
| Name:       | Relationship:       |
| Address:       |
| City:       | State:       | ZIP:       |
| Phone:       | Cell:       | FAX:       |
| Your Primary Care Physician:       |
| **Acknowledgement** |
| The above information is true to the best of my knowledge. I understand that I am financially responsible for all professional services, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance. |
| Patient Signature: | Date:       |
| Medical History |
| **My Primary Health Concerns** |
|       |       |
|       |       |
| **Current Medical Problems** |
|       |       |
|       |       |
| **Allergies** |
|       |       |       |
|       |       |       |
| **Medication Sensitivities / Reactions** |
|       |       |       |
|       |       |       |
| ­­­­­­­­­­­­­­­­­­­ **Current Medications - Prescription & Non-prescription** (name/dose/reason for taking) |
|       |       |
|       |       |
|       |       |
| **Current Supplements** (name/dose) |
|       |       |
|       |       |
|       |       |
|       |       |
| **Hospital Admissions / Surgeries** (Not including pregnancies) |
| Year | Illness/Operation | Year | Illness/Operation |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
| **Screening Tests** (most recent) |
| Screen | Date | Results? | Screen | Date | Results? |
| Cholesterol/Lipids |       |       | Dental Exam |       |       |
| Blood Sugar |       |       | Eye Exam |       |       |
| Pap Smear |       |       | Skin Exam |       |       |
| Mammogram |       |       | Colonoscopy |       |       |
| Bone Density |       |       | PSA (prostate test) |       |       |
| Vascular Ultrasound |       |       | Prostate Exam |       |       |
| **Immunizations** |
| Immunization | Year of Last | Immunization | Year of Last |
| Tetanus/Td |       | Pneumonia |       |
| Influenza (FLU) |       | Hepatitis |       |
| Other:      |       | Varicella |       |
| **Family History** |
| Check boxes if a blood relative has suffered any of the following –indicate which relative(s), and give details |
|  1.[ ]  Anemia |  2.[ ]  Alcoholism |  3.[ ]  Alzheimer’s  |  4.[ ]  Arthritis |
|  5.[ ]  Asthma |  6.[ ]  Bleeds easily |  7.[ ]  Cancer (type) |  8.[ ]  Diabetes |
|  9.[ ]  Epilepsy | 10.[ ]  Glaucoma | 11.[ ]  Hay fever | 12.[ ]  Heart disease |
| 13.[ ]  Hepatitis | 14.[ ]  Hypertension | 15.[ ]  Lipid disorder | 16.[ ]  Mental illness |
| 17.[ ]  Osteoporosis | 18.[ ]  Stroke | 19.[ ]  Thyroid dx | 20.[ ]        |
| Has your mother had a hip fracture after age 50?: [ ] Yes [ ]  No |
| Family History Details (indicate the number above, which relative(s) and explain): |
|       |       |       |       |
| **Medical History** |
| Enter: ‘**X**’ for all questions which have ever applied to you; ‘**C**’ for current ongoing problems |
|  | Decreased Hearing |  | Abdominal pain - chronic |
|  | Ringing in ear |  | Gall bladder trouble |
|  | Ear infections – frequent |  | Jaundice / Hepatitis |
|  | Dizzy spells |  | Have bowel movement every      day(s) |
|  | Fainting spells |  | Frequent: [ ]  Constipation [ ]  Diarrhea |
|  | Failing vision |  | Diverticulosis |
|  | Eye pain |  | Crohn’s / Colitis |
|  | Double or blurred vision |  | Bloody or tarry stools |
|  | Nose bleeds – recurrent |  | Hemorrhoids |
|  | Sinus trouble |  | Hernia; type-       |
|  | Sore throats – frequent |  | Urination – Overactive bladder |
|  | Hoarseness – prolonged |  |  Overnight > than twice |
|  | Dental problems: |  |  More than 8 times/24 hrs. |
|  | Floss teeth       times per week |  |  Urgency to urinate |
|  | Hay fever / Allergies |  | Decrease in urinary force/flow |
|  | Pneumonia / Pleurisy |  | Painful urination |
|  | Bronchitis / Chronic cough |  | Urine leakage with: Exercise/Straining/Cough |
|  | Shortness of breath: [ ]  Exertional [ ]  Lying flat |  | Blood in urine |
|  | Asthma / Wheezing |  | Kidney stones |
|  | Chest pain |  | Urine infections – frequent |
|  | High blood pressure |  | Sexually transmitted diseases: |
|  | Heart murmur |  | Recent weight- [ ] Gain [ ]  Loss:       lbs. |
|  | Rapid heart beat |  | Desired weight:       lbs. |
|  | Swollen ankles |  | Anemia |
|  | Irregular pulse |  | Bruise easily |
|  | Palpitations |  | Blood transfusions |
|  | Leg pain – when walking |  | Cancer; type(s)-      |
|  | Varicose Veins / Phlebitis |  | Chronic fatigue |
|  | Cold numb feet |  | Diabetes |
|  | Loss of appetite – recent |  | Seizures |
|  | Difficulty swallowing |  | Stroke |
|  | Heartburn |  | Tremor / hands shaking |
|  | Peptic ulcer |  | Numbness / tingling sensations |
|  | Persistent nausea / Vomiting |  | Headaches – frequent |
|  | Bone fracture / joint injury |  | Arthritis; type/location:      |
|  | Fractures after age 50? [ ] Yes [ ] No |  | Back pain – recurrent |
|  | Foot pain |  | Cups/day: [ ]  Coffee-      ; [ ]  Tea-       |
|  | Osteoporosis |  | Alcohol: [ ] Never [ ] Rarely [ ] Weekly [ ] Daily |
|  | Gout |  |  [ ] Beer [ ] Wine [ ] Liquor;# drinks:      |
|  | Rashes |  | Gotten drunk in the past month? [ ]  Yes [ ]  No |
|  | Hives |  | Felt the need to stop drinking? [ ]  Yes [ ]  No |
|  | Psoriasis |  | Smoking:­#     cigars/cigarettes/day;      yrs.  |
|  | Eczema |  |  Year quit smoking:       |
|  | Sleeping difficulty |  | Recreational drugs:      |
|  | Concentration difficulty |  | [ ]  Acupuncture; [ ]  Tattoos |
|  | Depression |  | Abuse: [ ]  Physical [ ]  Sexual [ ]  Other |
|  | Nervousness |  | Hair loss: [ ] Progressive [ ] Recent |
|  | Agitation |  | Do you have a lack of energy? |
|  | Memory loss |  | Do you have less strength/endurance? |
|  | Moodiness |  | Have you lost height?      inches |
|  | Suicidal thoughts |  | Decreased “enjoyment of life?” |
|  | Phobias |  | Are you sad and/or grumpy? |
|  | Mental illness |  | Recent deterioration in ability to play sports? |
|  | Feelings of worthlessness |  | Are you falling asleep after dinner? |
|  | Rheumatic Fever |  | Recent deterioration in work performance? |
|  | Scarlet Fever |  | Do you have a decrease in libido? |
|  | Chicken Pox |  | Satisfied with orgasm frequency? [ ]  Yes [ ]  No |
|  | Polio |  | Are you sexually active? Past Current |
|  | Mumps |  |  Opposite sex  | [ ]  [ ]  |
|  | German measles |  |  Same sex  | [ ]  [ ]  |
|  | Tuberculosis |  |  Single partner  | [ ]  [ ]  |
|  | Herpes |  |  Multiple partners  | [ ]  [ ]  |
|  | Aids / HIV |  |  # of sex partners in past year:      |
|  | Thyroid disease |  |  |
| **Females** (complete the following section) |
| Age when you started menstrual periods:       | Pregnancies:       |
| If menopausal, date of your last period:       | Abortions:       |
| Date of the 1st day of your last period:       | Miscarriages:       |
| Periods start every      days; # days of flow:      | Live births:       Age at 1st delivery:       |
| Periods: [ ] Regular [ ] Irregular [ ] Pain/Cramps | Did you ever breast feed? Yes [ ]  No [ ]   |
| Pain / Bleeding during or after sex: [ ]  Yes [ ]  No | Birth control method:       |
| Check only the following symptoms you currently experience: |
| [ ]  | Mental fogginess | [ ]  | Increase of breast size |
| [ ]  | Forgetfulness | [ ]  | Water retention |
| [ ]  | Depression  | [ ]  | Impatient, snappy behavior |
| [ ]  | Minor anxiety | [ ]  | Pelvic cramps |
| [ ]  | Mood change | [ ]  | Nausea |
| [ ]  | Difficulty falling asleep | [ ]  | Flabbiness and muscular weakness |
| [ ]  | Hot flashes  | [ ]  | Loss of hair |
| [ ]  | Night sweats | [ ]  | Lack of energy and stamina |
| [ ]  | Temperature swings | [ ]  | Loss of coordination and balance |
| [ ]  | Day-long fatigue  | [ ]  | Decreased sex drive |
| [ ]  | Decreased sense of sexuality | [ ]  | Decreased hair - armpit, pubic, body |
| [ ]  | Lessened self-image | [ ]  | Harder to reach climax |
| [ ]  | Dry eyes, skin and vagina  | [ ]  |       |
| [ ]  | Sagging breasts and loss of fullness | [ ]  |       |
| [ ]  | Pain with sexual activity | [ ]  |       |
| How do/did you feel during different days of the month of your cycle?       |
| How do/did you feel a few days before and during the period?       |
| How do/did you feel from the day of ovulation to the onset of heavy flow?       |
| Did you develop signs of deficiency after starting birth control pills?       |
| Did you feel miserable, gain weight or did breast size increase after starting birth control pills?       |
| Did you feel better after starting birth control pills?       |
| **Males** (complete the following section) |
| Symptoms you have at this time | None | Mild | Moderate | Severe | Extreme |
| Decline in your feeling of general well-being | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Joint pain and muscular ache | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Excessive sweating | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Sleep problems | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Increased need for sleep, often feeling tired | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Irritability | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Nervousness | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Anxiety | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Physical exhaustion / lack vitality | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Decrease in muscular strength | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Depressive mood | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Feeling that you have passed your peak | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Feeling burnt out, having hit rock bottom | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Decrease in beard growth | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Decrease in ability / frequency to perform sexually | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Decrease in the number of morning erections | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Decrease in sexual desire / libido | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Over the past month how often have you: | Not at All | < 1 time in 5 | < Half the time | Half the time | > Half the time | Almost Always |
| Had sensation of not emptying bladder completely after urinating? | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Had to urinate again less than 2 hrs. after urinating? | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Stopped and started urinating several times? | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Found it difficult to postpone urination? | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Had a weak urinary stream? | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Had to push or strain to begin urinating? | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| Typically up to urinate from bedtime to getting up? | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Adrenal** |
| Enter a rating (1-3) for each statement below that applies to you; leave all others blankRating: Leave blank =Never/Rarely; 1 =Occasionally/Slightly; 2 =Moderate intensity or frequency; 3 =Intense/Severe or frequent |
|    | I have experienced long periods of stress that have affected my well-being |
|    | I have had one or more severely stressful events that have affected my well-being |
|    | I have driven myself to exhaustion |
|    | I overwork with little play or relaxation for extended periods |
|    | I have had extended, severe or recurring respiratory infections |
|    | I have taken long term or intense steroid therapy (corticosteroids) |
|    | I tend to gain weight, especially around the middle (spare tire) |
|    | I have a history of alcoholism and/or drug abuse |
|    | I have environmental sensitivities |
|    | I have diabetes (type II, adult onset, NIDDM) |
|    | I suffer from post-traumatic distress syndrome |
|    | I suffer from anorexia |
|    | I have one or more other chronic illnesses or diseases |
|    | My ability to handle stress and pressure has decreased |
|    | I am less productive at work |
|    | I seem to have decreased in cognitive ability. I do not think as clearly as I used to  |
|    | My thinking is confused when hurried or under pressure |
|    | I tend to avoid emotional situations |
|    | I tend to shake or am nervous when under pressure |
|    | I suffer from nervous stomach indigestion when tense |
|    | I have many unexplained fears/anxieties |
|    | My sex drive is noticeably less than it used to be |
|    | I get lightheaded or dizzy when rising rapidly from a sitting or lying position |
|    | I have feelings of graying out or blacking out |
|    | I feel unwell much of the time |
|    | I notice that my ankles are sometimes swollen – and is worse in the evening |
|    | I usually need to lie down or rest after times of psychological or emotional pressure/stress |
|    | My muscles sometimes feel weaker than they should |
|    | My hands and legs get restless – experience meaningless body movements |
|    | I have become allergic or have increased frequency/severity of allergic reactions |
|    | Small irregular dark brown spots have appeared on my forehead, face, neck and shoulders |
|    | When I scratch my skin, a white line remains for a minute or more |
|    | I have unexplained and frequent headaches |
|    | I am frequently cold |
|    | I often become hungry, confused, shaky or somewhat paralyzed under stress |
|    | I have lost weight without reason while feeling very tired and listless |
|    | I have feelings of hopelessness or despair |
|    | I have decreased tolerance. People irritate me more |
|    | The lymph nodes (glands) in my neck are frequently swollen  |
|    | I often have to force myself in order to keep going. Everything seems like a chore |
|    | I am easily fatigued |
|    | I have difficulty getting up in the morning (don’t really wake up until about 10 AM) |
|    | I suddenly run out of energy |
|    | I usually feel much better and fully awake after the noon meal |
|    | I often have an afternoon low between 3 – 5 PM |
|    | I get low energy, moody or foggy if I do not eat regularly |
|    | I usually feel my best after 6 PM |
|    | I am often tired at 9-10 PM, but resist going to bed |
|    | I like to sleep late in the morning |
|    | My best, most refreshing sleep often comes between 7-9 AM |
|    | I often do my best work late at night (early in the morning) |
|    | If I don’t go to bed by 11 PM, I get a second burst of energy around 11 PM, often lasting until 1-2 AM |
|    | I get coughs/colds that stay around for several weeks |
|    | I have frequent or recurring bronchitis, pneumonia or other respiratory infections |
|    | I get asthma, colds and other respiratory involvement two or more times per year |
|    | I frequently get rashes, dermatitis, or other skin conditions |
|    | I have rheumatoid arthritis |
|    | I have allergies to several things in the environment |
|    | I have multiple chemical sensitivities |
|    | I have chronic fatigue syndrome |
|    | I get pain in the muscles of my upper back and lower neck for no apparent reason |
|    | I get pain in the muscles on the sides of my neck |
|    | I have insomnia or difficulty sleeping |
|    | I have Fibromyalgia |
|    | I suffer from asthma |
|    | I suffer from hay fever |
|    | I suffer from nervous breakdowns |
|    | My allergies are becoming worse (more severe, frequent or diverse) |
|    | The fat pads on palms of my hands and/or tips of my fingers are often red |
|    | I have a tenderness in my back near my spine at the bottom of my rib cage when pressed |
|    | I bruise more easily than I used to |
|    | I need coffee or some other stimulant to get going in the morning |
|    | I have swelling under my eyes upon rising that goes away after I have been up for a couple of hours |
|    | I often crave food high in fat and feel better with high fat foods |
|    | I use high fat foods to drive myself |
|    | I often use high fat foods and caffeine containing drinks (coffee, colas, chocolate) to drive myself |
|    | I often crave salt and/or foods high in salt. I like salty foods |
|    | I feel worse after high potassium foods (e.g. bananas, figs, raw potatoes), esp. if eaten in the morning |
|    | I crave high protein foods (meats, cheeses) |
|    | I crave sweet foods (pies, cakes, pastries, doughnuts, dried fruits, candies or desserts) |
|    | I feel worse if I miss or skip a meal |
|    | I have constant stress in my life or work |
|    | My dietary habits tend to be sporadic and unplanned |
|    | My relationships at work and/or home are unhappy |
|    | I do not exercise regularly |
|    | I eat lots of fruit |
|    | My life contains insufficient enjoyable activities |
|    | I have little control over how I spend my time |
|    | I restrict my salt intake |
|    | I have gum and/or tooth infections or abscesses |
|    | I have meals at irregular times |
|    | I feel better almost right away once a stressful situation is resolved |
|    | Regular meals decrease the severity of my symptoms |
|    | I often feel better after spending a night out with friends |
|    | I often feel better if I lie down |
|    | Other relieving factors:       |
|    | I am chronically fatigued; a tiredness that is not usually relieved by sleep (\*) |
|    | I sometimes feel weak all over (\*) |
|    | I have decreased tolerance for cold (\*) |
|    | I have times of nausea and vomiting for no apparent reason (\*) |
|    | I have low blood pressure (\*) |
| Women Only (next two questions) |
|    | Increasing symptoms of premenstrual syndrome (PMS): cramps, bloating, moodiness, irritability, emotional instability, headaches, tiredness, intolerance before my period (only some need be present) |
|    | My periods are heavy but often (almost) stop on the 4th day, & start up profusely on the 5th or 6th day |
| Place a check next to any of the following description that apply to you (\*\*) |
| Any areas that have become bluish-black color?: [ ]  inside lips/mouth, [ ]  vagina, [ ]  around nipples |
| [ ]  Increased darkening around bony areas, at skin folds, scars and in joint creases? |
| [ ]  Light colored patches on skin where it has lost its usual color?  | [ ]  Fainting spells?  |
| [ ]  Frequent unexplained diarrhea?  | [ ]  Easily become dehydrated?  |
| **Nutrition** |
| List any diets you have been on during the past 12 months, along with the reason(s) for following it, the benefits or problems you experienced with it, and the reason(s) for stopping any diet: |
|       |
|       |
|       |
| **Exercises** |
|       |
|       |
|       |
| **Current Sources of Stress** |
|       |
|       |
|       |
| **Miscellaneous** |
| Additional information you would like to share, or to elaborate on previous questions |
|       |
|       |
|       |
| Symptom Flowsheet [blank=none; 1=mild; 2=moderate; 3=severe; 4=extreme] |
| Symptom Date: |       |       |       |       |       |       |       |
| Arthritis/stiffness |  |  |  |  |  |  |  |
| Joint or back pain |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Muscle flabbiness or weakness |  |  |  |  |  |  |  |
| Weight - gain |  |  |  |  |  |  |  |
| Weight - loss |  |  |  |  |  |  |  |
| Headaches |  |  |  |  |  |  |  |
| Blood pressure - low |  |  |  |  |  |  |  |
| Blood pressure - high |  |  |  |  |  |  |  |
| Heart palpitation |  |  |  |  |  |  |  |
| Drowsiness |  |  |  |  |  |  |  |
| Insomnia/sleep disturbances |  |  |  |  |  |  |  |
| Fatigue |  |  |  |  |  |  |  |
| Forgetfulness |  |  |  |  |  |  |  |
| Heat intolerance |  |  |  |  |  |  |  |
| I’m sensitive to temperature swings |  |  |  |  |  |  |  |
| I experience temperature swings |  |  |  |  |  |  |  |
| Cold hands & feet (whole body feels cold) |  |  |  |  |  |  |  |
| Dizziness |  |  |  |  |  |  |  |
| Food cravings |  |  |  |  |  |  |  |
| Diarrhea |  |  |  |  |  |  |  |
| Bladder Symptoms |  |  |  |  |  |  |  |
| Acne |  |  |  |  |  |  |  |
| Hair - dry |  |  |  |  |  |  |  |
| Hair – facial |  |  |  |  |  |  |  |
| Hair - loss from scalp |  |  |  |  |  |  |  |
| Hair – loss from pubic, armpit & body |  |  |  |  |  |  |  |
| Skin - dry |  |  |  |  |  |  |  |
| Skin - oily |  |  |  |  |  |  |  |
| Skin - wrinkles |  |  |  |  |  |  |  |
| Excessive sweating |  |  |  |  |  |  |  |
| Anxiety |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |
| Irritability |  |  |  |  |  |  |  |
| Mood swings |  |  |  |  |  |  |  |
| Decreased libido |  |  |  |  |  |  |  |
| Decreased sense of sexuality |  |  |  |  |  |  |  |
| Decreased sexual arousability |  |  |  |  |  |  |  |
| Harder to reach climax |  |  |  |  |  |  |  |
| Amenorrhea (no period) |  |  |  |  |  |  |  |
| Breakthrough bleeding |  |  |  |  |  |  |  |
| Cramps |  |  |  |  |  |  |  |
| Endometriosis, Fibroids, Adenomyosis |  |  |  |  |  |  |  |
| Heavy/irregular periods |  |  |  |  |  |  |  |
| Breasts - Fibrocystic |  |  |  |  |  |  |  |
| Breasts - Sagging/less fullness |  |  |  |  |  |  |  |
| Breasts - Tenderness |  |  |  |  |  |  |  |
| Breasts - Size increased/fullness |  |  |  |  |  |  |  |
| Hot flashes |  |  |  |  |  |  |  |
| Night sweats |  |  |  |  |  |  |  |
| Nipple tenderness |  |  |  |  |  |  |  |
| PMS (premenstrual syndrome) |  |  |  |  |  |  |  |
| Vaginal dryness |  |  |  |  |  |  |  |
| Water retention/bloating |  |  |  |  |  |  |  |
| Erection problems |  |  |  |  |  |  |  |
| Patient Signature: | Date:      |