

**SPECIALTY PHARMACY
NATURAL HORMONE REPLACEMENT THERAPY
SYMPTOMOLOGY QUESTIONNAIRE**

Patient Name: _____ Date: _____

Try to fill out this questionnaire as quickly as possible, as your first instinctive answer is usually more accurate. Please circle one number for every single symptom listed. Do not try to determine the cause of the symptoms – just mark them as best as you can – regardless of the cause (i.e., job stress, bad diet, etc.).

Just give an average as to how each symptom has bothered you over the last 1-2 months using the #'s 1-10 going from rare to occasional or very often. This is strictly confidential and will be seen by your pharmacist and physician only.

	Rare			Occasional				Very Often		
	1	2	3	4	5	6	7	8	9	10
HOT FLASHES	1	2	3	4	5	6	7	8	9	10
NIGHT SWEATS	1	2	3	4	5	6	7	8	9	10
FOGGY THINKING	1	2	3	4	5	6	7	8	9	10
VAGINAL DRYNESS	1	2	3	4	5	6	7	8	9	10
DEPRESSION	1	2	3	4	5	6	7	8	9	10
URINARY INCONTINENCE	1	2	3	4	5	6	7	8	9	10
BLOATING	1	2	3	4	5	6	7	8	9	10
WATER RETENTION	1	2	3	4	5	6	7	8	9	10
BREAST TENDERNESS	1	2	3	4	5	6	7	8	9	10
HEADACHES	1	2	3	4	5	6	7	8	9	10
FATIGUE	1	2	3	4	5	6	7	8	9	10
FIBROCYSTIC BREASTS	1	2	3	4	5	6	7	8	9	10
MOOD/EMOTIONAL SWINGS	1	2	3	4	5	6	7	8	9	10
WEIGHT GAIN	1	2	3	4	5	6	7	8	9	10
HEAVY BLEEDING	1	2	3	4	5	6	7	8	9	10
IRRITABLE	1	2	3	4	5	6	7	8	9	10
ANXIETY	1	2	3	4	5	6	7	8	9	10
PAINFUL JOINTS	1	2	3	4	5	6	7	8	9	10
INSOMNIA/STAYING ASLEEP	1	2	3	4	5	6	7	8	9	10
LOW SEX DRIVE	1	2	3	4	5	6	7	8	9	10
LOW SELF ESTEEM	1	2	3	4	5	6	7	8	9	10
PAINFUL INTERCOURSE	1	2	3	4	5	6	7	8	9	10
INABILITY TO REACH ORGASM	1	2	3	4	5	6	7	8	9	10
THINNING SKIN	1	2	3	4	5	6	7	8	9	10
STRESS	1	2	3	4	5	6	7	8	9	10
MEMORY	1	2	3	4	5	6	7	8	9	10
CONFUSION	1	2	3	4	5	6	7	8	9	10