FEMALE FORM

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| --- | --- | --- | --- |
| Name: |  | Date: |  |
| Contact phone: | | Email: | |

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| --- | --- | --- | --- | --- |
| Symptoms | Never | Mild | Moderate | Severe |
| Depressive Mood |  |  |  |  |
| Fatigue |  |  |  |  |
| Inability to concentrate / Focus |  |  |  |  |
| Hot flashes / Night sweats |  |  |  |  |
| Mental Confusion |  |  |  |  |
| Sleep Problems |  |  |  |  |
| Mood Changes/irritability |  |  |  |  |
| Low Sexual Desire |  |  |  |  |
| Bloating |  |  |  |  |
| Weight Gain |  |  |  |  |
| Vaginal Dryness |  |  |  |  |
| Dry Wrinkled Skin |  |  |  |  |
| Hair Falling Out |  |  |  |  |
| Cold All The Time |  |  |  |  |
| Joint Pain |  |  |  |  |
| Decline In General Well Being |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Family History | | | | |
| Heart Disease |  | No |  | YES |
| Diabetes |  | No |  | YES |
| Osteoporosis |  | No |  | YES |
| Alzheimer’s Dementia |  | No |  | YES |
| Cancer |  | No |  | YES |