Women's Wellness Center
Hormone Health Questionnaire
Female – Baseline

Name _____ **Age** _____ **Date** _____

Which of the following symptoms apply to you at this time? Please mark the appropriate box for each symptom. For symptoms that only occur around the time of your period (just before or during your period), mark "Cyclic". For symptoms that do not apply, please mark "None".

Symptom	None	Mild	Moderate	Severe	Cyclic	Comments
1. Hot Flashes	☐	☐	☐	☐	☐	_____
2. Night Sweats	☐	☐	☐	☐	☐	_____
3. Insomnia	☐	☐	☐	☐	☐	_____
4. Irritability	☐	☐	☐	☐	☐	_____
5. Anxious	☐	☐	☐	☐	☐	_____
6. Depressed, Tearful	☐	☐	☐	☐	☐	_____
7. Foggy Thinking	☐	☐	☐	☐	☐	_____
8. Fatigue	☐	☐	☐	☐	☐	_____
9. Headaches	☐	☐	☐	☐	☐	_____
10. Breast tenderness	☐	☐	☐	☐	☐	_____
11. Weight Gain	☐	☐	☐	☐	☐	_____
12. Heavy Periods	☐	☐	☐	☐	☐	_____
13. Irregular Periods	☐	☐	☐	☐	☐	_____
14. Low Sex Drive	☐	☐	☐	☐	☐	_____
15. Reduced Orgasm	☐	☐	☐	☐	☐	_____
16. Vaginal Dryness	☐	☐	☐	☐	☐	_____
17. Pain w/ Intercourse	☐	☐	☐	☐	☐	_____
18. Urinary Leakage	☐	☐	☐	☐	☐	_____
19. Urinary Frequency	☐	☐	☐	☐	☐	_____
20. Fecal Leakage	☐	☐	☐	☐	☐	_____
21. Hair Loss	☐	☐	☐	☐	☐	_____
22. Brittle Nails	☐	☐	☐	☐	☐	_____
23. Constipation	☐	☐	☐	☐	☐	_____
24. Heart Palpitations	☐	☐	☐	☐	☐	_____
25. Joint/Muscle Pains	☐	☐	☐	☐	☐	_____