Hormone Questionnaire

Name _____ Date _____

Please rank the follow complaints 1 to 10, with 1 being lowest in severity, and 10 being highest.

1. Anxiety _____
2. PMS _____
3. Heavy Bleeding _____
4. Insomnia _____
5. Food Craving _____
6. Hot Flashes _____
7. Vaginal Dryness _____
8. Urinary Incontinence _____
9. Bone Loss _____
10. Brain Fog _____
11. Loss of libido _____
12. Muscle Loss/Weakness _____
13. Fatigue _____
14. Depression _____
15. Mental Clarity/Memory _____
16. Motivation _____
17. Weight Gain _____
18. Muscle Pain _____
19. Swelling _____
20. Loss of outer eyebrows _____
21. Coldness _____
22. Constipation _____
23. Palpitations _____