Female Hormone Questionnaire

Name________________________ D.O.B____________

Please check all symptoms which apply to you.

- Hot Flashes
- Breast Tenderness
- Thinning Skin
- Foggy Thinking
- Hair Loss
- Water Retention
- Depression
- Rapid Aging
- Increased Urinary Urge

- Night Sweats
- Morning Fatigue
- Irritability
- Bleeding Changes
- Palpitations
- Infertility
- Fibroids
- Salt Cravings
- Head Aches
- Sweating
- Cystic Breasts
- Sugar Cravings
- Anxiousness

- Aches and Pains
- Dry Skin/Hair
- Cold Body Temp.
- Fibromyalgia
- Constipation
- Weight Gain
- Eye Swelling
- Hearing Loss
- Brittle Nails
- Hoarseness

- Decreased Libido
- Abdominal Weight Gain
- Unwanted Body Hair
- Vaginal Dryness
- Loss of Muscle Mass
- Facial Hair
- Acne

- Decreased Stamina
- Carbohydrate Craving
- Low Blood Sugar
- Stress