

# HORMONE FOLLOW UP VISIT

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ AGE \_\_\_\_\_

Current Hormone Therapy				
Brand	Type	Milligrams	How often do you use them	How long have you used them

**Date of last period:**

Describe periods since last visit. (For example: Are your periods regular? How many days from start of one period to the start of the next one? Number of days of flow. Describe your flow, is it light or heavy?. Any bleeding between periods?):

**List any recent new medications, supplements, dietary changes, or medical diagnosis:**

**List any new symptoms, problems, questions, or concerns:**

***Patients: Rate symptoms on page 2 of this form as you are experiencing them today or only since last visit.***

**Office Notes/Physician Assessment:**

Rate applicable symptoms from 1-10 of each category 1 being mild - 10 severe:

**Estrogens**

Estrogen Deficiency		Estrogen Excess	
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Depressed	<input type="checkbox"/> Mood Swings (PMS)	<input type="checkbox"/> Fibrocystic Breasts
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Tender Breasts	<input type="checkbox"/> Uterine Fibroids
<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Heart Palpation	<input type="checkbox"/> Water Retention	<input type="checkbox"/> Weight Gain in Hips
<input type="checkbox"/> Foggy Thinking	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Nervous	<input type="checkbox"/> Bleeding Changes
<input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Dry Skin/Hair	<input type="checkbox"/> Irritable	<input type="checkbox"/> Headaches
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Headaches	<input type="checkbox"/> Anxious	<input type="checkbox"/> Heavy Periods
<input type="checkbox"/> Tearful		<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Breast Cancer
		<input type="checkbox"/> Cold Body Temperature	<input type="checkbox"/> Weight Gain/Waist
		<input type="checkbox"/> Elevated Triglycerides	<input type="checkbox"/> Low Libido

**PROGESTERONE DEFICIENCY**

<input type="checkbox"/> Candida Infections	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Break-thru Bleeding
<input type="checkbox"/> Fibrocystic Breasts	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fibroids
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Heavy Periods	<input type="checkbox"/> PMS
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Stressed Easily	<input type="checkbox"/> Irritability	<input type="checkbox"/> Irregular Periods
<input type="checkbox"/> Headaches	<input type="checkbox"/> Water Retention	<input type="checkbox"/> Cramps	<input type="checkbox"/> Hypothyroid

**Androgens (DHEA and Testosterone)**

Androgen Deficiency		Androgen Excess	
<input type="checkbox"/> Low Libido	<input type="checkbox"/> Depressed	<input type="checkbox"/> Excessive Facial Hair	<input type="checkbox"/> Oily Skin
<input type="checkbox"/> Vaginal Dryness	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Excessive Body Hair	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Thinning Pubic Hair	<input type="checkbox"/> Increased Acne	<input type="checkbox"/> Hair Loss (scalp)
<input type="checkbox"/> Aches/Pains/Arthritis	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Nervous, Irritable
<input type="checkbox"/> Memory Lapses	<input type="checkbox"/> Decrease Muscle Mass	<input type="checkbox"/> Elevated triglycerides	
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Thinning Skin		
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Fibromyalgia		

**Cortisol Imbalance**

Cortisol Deficiency		Cortisol Excess	
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cold Body Temp.	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Sugar Cravings	<input type="checkbox"/> Irritable	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Headaches
<input type="checkbox"/> Allergies	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Stress
<input type="checkbox"/> Chemical Sensitivity	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Weight Gain/Waist	<input type="checkbox"/> Cold Body Temp.
<input type="checkbox"/> Stress	<input type="checkbox"/> Aches / Pains	<input type="checkbox"/> Loss of Muscle Mass	<input type="checkbox"/> Sugar Cravings
<input type="checkbox"/> low blood sugar		<input type="checkbox"/> Thinning Skin	<input type="checkbox"/> Low Libido
		<input type="checkbox"/> Elevated triglycerides	<input type="checkbox"/> Hair Loss
		<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Increased Facial Hair
		<input type="checkbox"/> Irritable	<input type="checkbox"/> Increased Body Hair
		<input type="checkbox"/> Anxious	<input type="checkbox"/> Acne
		<input type="checkbox"/> Memory Lapse	<input type="checkbox"/> Nervous

**Thyroid Deficiency**

<input type="checkbox"/> Tired or Exhausted	<input type="checkbox"/> Difficult to Concentrate	<input type="checkbox"/> Nails Breaking / Brittle	<input type="checkbox"/> Infertility Problems
<input type="checkbox"/> Sad or Depressed	<input type="checkbox"/> Mood Changes	<input type="checkbox"/> Aches / Pains	<input type="checkbox"/> Slowed Reflexes
<input type="checkbox"/> Cold Body Temp.	<input type="checkbox"/> Swelling / Puffy Eyes	<input type="checkbox"/> Low Libido	<input type="checkbox"/> Constipation
<input type="checkbox"/> Cold Hands & Feet	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Thick Tongue
<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sleep Disturbances	<input type="checkbox"/> Slow Ankle Reflex
<input type="checkbox"/> Can't Lose Weight	<input type="checkbox"/> Slow Pulse Rate	<input type="checkbox"/> Bone Loss	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Memory Lapse	<input type="checkbox"/> Decreased Sweating	<input type="checkbox"/> Decreased Muscle	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Hair Dry or Brittle	<input type="checkbox"/> Mass	<input type="checkbox"/> Thinning Skin