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BHRT Symptom Update

Date______________________

Name____ Date of Birth ___________________

Address____

Home Phone (_____)____________________ Cell Phone (_____)__________________

Have there been any changes in any of your medications in the past year? If so, please list:

____

Have there been any changes to your monthly period?______________________________________

Please check all symptoms below that apply (this is very important to the evaluation process)

Symptoms of **low Progesterone**?

__ Swollen Breasts
__ Anxiety/Irritability
__ Irregular menses
__ Infertility
__ Weight Gain
__ Mood Swings
__ PMS
__ Joint Pain
__ Food Cravings
__ Headaches
___per week
__ Cramping
__ Acne
__ Low Sex Drive
__ Depression
__ Fuzzy Thinking
__ Low Energy

Symptoms of **low Estrogen**?

__ Hot Flashes
__ Dry Skin
__ Foggy Thinking
__ Painful Intercourse
__ Night Sweats
___per week
__ Yeast Infections
__ Bone Loss
__ Weight Gain
__ Insomnia
___per week
__ Heart Palpitations
__ Low Sex Drive
__ Vaginal Dryness/Atrophy
__ Memory Lapses
__ Depression
__ Headaches
___per week

Symptoms of **low Testosterone?**

__ Depression
__ Joint Pain
__ Heart Palpitations
__ Fibromyalgia
__ Urinary Incontinence
__ Low Sex Drive
__ Memory Lapses
__ Vaginal Dryness
__ Low Energy
__ Bone Loss
__ Muscle Weakness
__ Thinning Skin/Scalp Hair Loss

Have any symptoms become more frequent/bothersome in the past few months?_______________

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Filling out a Symptom Update Sheet gives the pharmacist permission to make dosing change suggestions to your doctor. If you do not want changes, there is no reason to fill out the sheet. If you do not want the new changes filled right away, but put "On Hold" for the next time you need them filled, please check this box. ☐