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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?

- |   |   |
|---|---|
| <input type="checkbox"/> Swollen Breasts      | <input type="checkbox"/> Headaches      |
| <input type="checkbox"/> Anxiety/Irritability | <input type="checkbox"/> _____ per week |
| <input type="checkbox"/> Irregular menses     | <input type="checkbox"/> Cramping       |
| <input type="checkbox"/> Infertility          | <input type="checkbox"/> Acne           |
| <input type="checkbox"/> Weight Gain          | <input type="checkbox"/> Low Sex Drive  |
| <input type="checkbox"/> Mood Swings          | <input type="checkbox"/> Depression     |
| <input type="checkbox"/> PMS                  | <input type="checkbox"/> Fuzzy Thinking |
| <input type="checkbox"/> Joint Pain           | <input type="checkbox"/> Low Energy     |
| <input type="checkbox"/> Food Cravings        |   |

### Symptoms of low Estrogen?

- |  |  |
|--|--|
| <input type="checkbox"/> Hot Flashes         | <input type="checkbox"/> Insomnia                |
| <input type="checkbox"/> Dry Skin            | <input type="checkbox"/> _____ per week          |
| <input type="checkbox"/> Foggy Thinking      | <input type="checkbox"/> Heart Palpitations      |
| <input type="checkbox"/> Painful Intercourse | <input type="checkbox"/> Low Sex Drive           |
| <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Vaginal Dryness/Atrophy |
| <input type="checkbox"/> _____ per week      | <input type="checkbox"/> Memory Lapses           |
| <input type="checkbox"/> Yeast Infections    | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Bone Loss           | <input type="checkbox"/> Headaches               |
| <input type="checkbox"/> Weight Gain         | <input type="checkbox"/> _____ per week          |

### Symptoms of low Testosterone?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Depression         | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Low Energy                    |
| <input type="checkbox"/> Joint Pain         | <input type="checkbox"/> Low Sex Drive        | <input type="checkbox"/> Bone Loss                     |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Memory Lapses        | <input type="checkbox"/> Muscle Weakness               |
| <input type="checkbox"/> Fibromyalgia       | <input type="checkbox"/> Vaginal Dryness      | <input type="checkbox"/> Thinning Skin/Scalp Hair Loss |

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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.**