

Patient Details

Name:

Phone number:

email:

Mental/Emotional/Psychological symptoms

	<i>mild</i>	<i>moderate</i>	<i>severe</i>
Memory loss / forgetfulness / word finding difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling overwhelmed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weeping / crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bursts of anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flat mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical Symptoms

	<i>mild</i>	<i>moderate</i>	<i>severe</i>
Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No Energy / fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / feeling faint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry, papery, itching or crawling skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss / hair thinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased facial hair / chin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pimples / Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore, swollen or tender breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine / headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive problems / IBS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Receding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning tongue/ mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness aches & pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of muscle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling extremities / restless legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Genitourinary Symptoms

	<i>mild</i>	<i>moderate</i>	<i>severe</i>
Loss of libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty reaching orgasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder issues (UTIs / Incontinence)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

