Menopause Treatment Assessment

Name: ________________________ ____________ Current Age ____
date

Are you currently taking bio-identical hormones?
If so, which ones:

Name	Strength	Base:	Amount	Times Each Day:	Location(s) on Body
[eg: Bi-est	eg:30mg/ml	eg: oils, gel, etc	eg:3&2 drops	eg: morning & bedtime	eg: soft forearm & buttocks]

Day of month you begin estrogen? ____ Day of month you stop estrogen? ____
Day of month you begin progesterone? ____ Day of month you stop progesterone? ____
Day of month you begin DHEA? ____ Day of month you stop DHEA? ____
Day of month you begin testosterone? ____ Day of month you stop testosterone? ____

Do you have any of the following symptoms?

grade symptom:
0 = do not have
1 = have occasionally
2 = have frequently
a = mild
b = moderate
c = severe
eg: "2c" = frequent & severe

Hot flashes? ____
Warm rushes? ____
Night sweats? ____
Kicking covers off at night? ____
Vaginal dryness? ____

Breast tenderness? ____
Nipple tenderness? ____
Breast fullness? ____
Breast pain? ____
Other (please specify): ________

Times/night up to urinate? ____
Sleep disturbance? ____
Pubic hair loss? ____
Weight gain? ____

Please rate on a scale of 0-10 (10 being "great") your:

Energy: ____ Sleep: ____ Memory: ____
Mood: Libido: