APOTHECARY OPTIONS

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Bio-Identical Hormone Replacement Therapy Patient Symptom Survey

Symptom	**Absent**	**Mild**	**Moderate**	**Severe**
Fibrocystic Breasts	_____	_____	_____	_____
Weight Gain	_____	_____	_____	_____
Craving for Sweets	_____	_____	_____	_____
Heavy / Irregular Menses	_____	_____	_____	_____
Breakthrough Bleeding (days 5-12)	_____	_____	_____	_____
Breakthrough Bleeding (days 13-21)	_____	_____	_____	_____
Uterine Fibroids	_____	_____	_____	_____
Cramps / PMS symptoms	_____	_____	_____	_____
Hot Flashes	_____	_____	_____	_____
Night Sweats	_____	_____	_____	_____
Sleep Disturbances / Insomnia	_____	_____	_____	_____
Dry Skin/Hair	_____	_____	_____	_____
Heart Palpitations	_____	_____	_____	_____
Acne	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Loss of Memory	_____	_____	_____	_____
Foggy Thinking / Forgetfulness	_____	_____	_____	_____
Irritability	_____	_____	_____	_____
Mood Swings	_____	_____	_____	_____
Breast Tenderness / Swelling	_____	_____	_____	_____
Fluid Retention / Puffiness/ Bloating	_____	_____	_____	_____
Fatigue	_____	_____	_____	_____
Bladder Symptoms / Incontinence	_____	_____	_____	_____
Arthritis / Aches and Pains	_____	_____	_____	_____
Decreased Sex Desire / Enjoyment	_____	_____	_____	_____
Vaginal Dryness	_____	_____	_____	_____
Cold Body Temperature	_____	_____	_____	_____
Frequent Constipation	_____	_____	_____	_____
Thin or Brittle Nails	_____	_____	_____	_____
Hair Loss	_____	_____	_____	_____

Your Name: **Date:**