



Check **ABSENT, MILD, MODERATE OR SEVERE** on any that you currently have or have had experienced in the past 3 months. Check **ABSENT** if you have not experienced any of the symptoms.

FEMALE

PATIENT NAME:					DATE:				
	ABSENT	MILD	MODERATE	SEVERE		ABSENT	MILD	MODERATE	SEVERE
Anxiety					Bladder symptoms				
Breast tenderness					PMS symptoms				
Depression					Joint pain				
Dry skin/hair					Memory loss				
Fibrocystic breast (Breast Lumps)					Headaches				
Heavy menses					Fatigue				
Irregular menses					Fluid retention				
Irritability					Hot flashes				
Cold body temperature					Mood Swings				
Harder to reach climax					Night sweats				
Difficulty falling asleep					Hair Loss				
Vaginal dryness					Decreased sex drive				
Weight gain					Interrupted sleep				

SIGNATURE: _____

MALE

PATIENT NAME:					DATE:				
	ABSENT	MILD	MODERATE	SEVERE		ABSENT	MILD	MODERATE	SEVERE
Aches & Pain					Anxiety				
Loss of initiative/drive					Hair Loss				
Difficulty falling asleep					Frequent Urination				
Carb. Cravings					Mood Swings				
Decreased Muscle Mass					Weak urine stream				
Fatigue					Headaches				
Foggy Mind					Weight Gain				
Interrupted Sleep					Irritability				
Cold Body Temperature					Night Sweats				
Difficulty obtaining erection					Decreased Sex drive				
Difficulty maintaining erection					Depression				
Waking up un-refreshed					Poor Stamina				

SIGNATURE: _____