For Clinician Use:

Weight _____ B/P _____ HR _____ Temp _____ O2 Sat _____

Name:_____ Birthdate: _____ Date: _____

Please rate your symptoms based on how you have been feeling for the **past month**.
1 = minor concern; 5 = significant concern for frequency of that symptom.

Sensitivity to cold	0 1 2 3 4 5	Decreased body hair	0 1 2 3 4 5
Poor blood circulation	0 1 2 3 4 5	Increased facial/body hair	0 1 2 3 4 5
Difficulty losing weight	0 1 2 3 4 5	Hot flashes	0 1 2 3 4 5
Morning fatigue	0 1 2 3 4 5	Fibrocystic breasts	0 1 2 3 4 5
Constant fatigue	0 1 2 3 4 5	Heavy/irregular periods	0 1 2 3 4 5
Depression	0 1 2 3 4 5	Excessive sweating	0 1 2 3 4 5
Headaches	0 1 2 3 4 5	Night sweats	0 1 2 3 4 5
Decreased memory	0 1 2 3 4 5	Vaginal dryness	0 1 2 3 4 5
Decreased concentration	0 1 2 3 4 5	Bladder infections	0 1 2 3 4 5
Puffiness in face	0 1 2 3 4 5	Anxiety	0 1 2 3 4 5
Ear/nose/throat infections	0 1 2 3 4 5	Breast tenderness	0 1 2 3 4 5
Constipation	0 1 2 3 4 5	Irritable	0 1 2 3 4 5
Heartburn	0 1 2 3 4 5	Nervousness	0 1 2 3 4 5
Nosebleeds	0 1 2 3 4 5	Heavy periods/cramps	0 1 2 3 4 5
Morning joint stiffness	0 1 2 3 4 5	Fluid retention	0 1 2 3 4 5
Hoarse voice	0 1 2 3 4 5	Decreased sex drive	0 1 2 3 4 5
Ringing in ears	0 1 2 3 4 5	Decreased erection quality	0 1 2 3 4 5
Hypoglycemia	0 1 2 3 4 5	Decreased stamina/vitality	0 1 2 3 4 5
Dry skin (face/elbows/legs)	0 1 2 3 4 5	Muscle pain	0 1 2 3 4 5
Brittle nails	0 1 2 3 4 5	Joint pain	0 1 2 3 4 5
Hair loss	0 1 2 3 4 5	Poor recovery after exercise	0 1 2 3 4 5
Slow growing hair	0 1 2 3 4 5	Sleep quality	0 1 2 3 4 5
Low urine output	0 1 2 3 4 5	Tense muscles	0 1 2 3 4 5
Easily stressed	0 1 2 3 4 5	Dry Eyes	0 1 2 3 4 5
Feel burned out	0 1 2 3 4 5	Diarrhea	0 1 2 3 4 5
Tired but wired	0 1 2 3 4 5	Gas	0 1 2 3 4 5
Craves sugar	0 1 2 3 4 5	Bloating	0 1 2 3 4 5
Craves Salt	0 1 2 3 4 5	Difficulty urinating	0 1 2 3 4 5

What are your three most concerning symptoms?

1: _____ 2: _____ 3: _____

MEN: Date of last testosterone injection: _____ **Women:** First day of your last period: _____

If you are taking thyroid: Did you take your dose this morning? Y N