NAME:______________________________ DATE:______________________

HORMONE REPLACEMENT THERAPY PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE
Anxiety	________	________	________	________
Arthritis	________	________	________	________
Bladder Symptoms	________	________	________	________
Breakthrough Bleeding	________	________	________	________
Breast Tenderness	________	________	________	________
Cramps	________	________	________	________
Decreased Sex Drive	________	________	________	________
Depression	________	________	________	________
Dry Skin/Hair	________	________	________	________
Fatigue	________	________	________	________
Fibrocystic Breast	________	________	________	________
Fluid Retention	________	________	________	________
Hair Loss	________	________	________	________
Harder to Reach Climax	________	________	________	________
Headaches	________	________	________	________
Heavy/Irregular menses	________	________	________	________
Hot Flashes	________	________	________	________
Irritability	________	________	________	________
Loss of Memory	________	________	________	________
Mood Swings	________	________	________	________
Night Sweats	________	________	________	________
PMS	________	________	________	________
Sleep Disturbances/Insomnia	________	________	________	________
Vaginal Dryness	________	________	________	________
Weight Gain	________	________	________	________

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