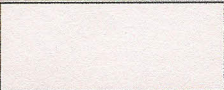


PATIENT'S NAME: \_\_\_\_\_



**5** **Symptoms**

Please indicate the symptoms you are experiencing as:  (none),  (mild),  (moderate),  (severe).  
 For example if you are moderately anxious you would indicate this by darkening the 2 next to 'anxious' e.g.  Anxious

WOMEN ONLY				MEN ONLY			
<b>E2DOM</b>	<b>E2DOM</b>	<b>ADRENAL</b>	<b>ADRENAL</b>	<b>E2DOM</b>	<b>E2DOM</b>	<b>ADRENAL</b>	<b>ADRENAL</b>
<input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Incontinence <input type="checkbox"/> Bleeding Changes <input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Water Retention <input type="checkbox"/> Tender Breasts <input type="checkbox"/> Fibrocystic Breasts <input type="checkbox"/> Increased Forgetfulness <input type="checkbox"/> Foggy Thinking <input type="checkbox"/> Tearful <input type="checkbox"/> Depressed <input type="checkbox"/> Mood Swings <input type="checkbox"/> Stress <input type="checkbox"/> Morning Fatigue <input type="checkbox"/> Evening Fatigue <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Decreased Stamina <input type="checkbox"/> Anxious <input type="checkbox"/> Irritable <input type="checkbox"/> Nervous <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Allergies <input type="checkbox"/> Headaches <input type="checkbox"/> Sugar Cravings <input type="checkbox"/> Dizzy Spells	<input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Goiter <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hair Dry or Brittle <input type="checkbox"/> Nails Breaking or Brittle <input type="checkbox"/> Constipation <input type="checkbox"/> Slow Pulse Rate <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Infertility Problems <input type="checkbox"/> Acne <input type="checkbox"/> Increased Facial / Body Hair <input type="checkbox"/> Scalp Hair Loss <input type="checkbox"/> Weight Gain-Hips <input type="checkbox"/> Weight Gain-Waist <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Decreased Libido <input type="checkbox"/> Decreased Muscle Size <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Rapid Aging <input type="checkbox"/> Aches and Pains <input type="checkbox"/> Bone Loss <input type="checkbox"/> Height (inches) _____ <input type="checkbox"/> Weight (lbs) _____	<input type="checkbox"/> Decreased Urine Flow <input type="checkbox"/> Increased Urinary Urge <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Weight Gain-Chest / Hips <input type="checkbox"/> Weight Gain-Waist <input type="checkbox"/> Decreased Libido <input type="checkbox"/> Decreased Erections <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Elevated Triglycerides <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats <input type="checkbox"/> Decreased Mental Sharpness <input type="checkbox"/> Increased Forgetfulness <input type="checkbox"/> Decreased Muscle Size <input type="checkbox"/> Decreased Flexibility <input type="checkbox"/> Sore Muscles <input type="checkbox"/> Increased Joint Pain <input type="checkbox"/> Neck or Back Pain <input type="checkbox"/> Bone Loss <input type="checkbox"/> Rapid Aging <input type="checkbox"/> Thinning Skin <input type="checkbox"/> Decreased Stamina	<input type="checkbox"/> Burned Out Feeling <input type="checkbox"/> Stress <input type="checkbox"/> Morning Fatigue <input type="checkbox"/> Evening Fatigue <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Apathy <input type="checkbox"/> Depressed <input type="checkbox"/> Mental Fatigue <input type="checkbox"/> Anxious <input type="checkbox"/> Irritable <input type="checkbox"/> Nervous <input type="checkbox"/> Headaches <input type="checkbox"/> Sugar Cravings <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Cold Body Temperature <input type="checkbox"/> Goiter <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hair Dry or Brittle <input type="checkbox"/> Nails Breaking or Brittle <input type="checkbox"/> Constipation <input type="checkbox"/> Slow Pulse Rate <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Heart Palpitations <input type="checkbox"/> Infertility Problems <input type="checkbox"/> Allergies <input type="checkbox"/> Height (inches) _____ <input type="checkbox"/> Weight (lbs) _____				

**6** **Hormone Product Use**

Indicate any hormone(s) you have used in the past 2 months as shown in the example below.

HORMONE THERAPIES	examples	1	2	3	4
hormone type	Estrogen Progesterone Testosterone DHEA Cortisol				
brand used	Compounded				
delivery	Topical, Oral, Sublingual				
amount (mg/day)	20 mg/day				
date & time last used prior to sample collection	4/29/06 8:30pm				
# x's/day & days/month	Once/14 days				
how long used	6-months				

**COMMENTS:** (Please do not use additional sheets of paper.)

**Internal Use Only**

