FEMALE HORMONE TRACKING SHEET

Name: _____ **Date:** _____/_____/_____

Circle the appropriate number indicating the intensity of your problem:

0 = NO PROBLEM **1** = MILD PROBLEM **2** = MODERATE PROBLEM

3 = SEVERE PROBLEM **4** = EXTREME PROBLEM

HOT FLASHES	0	1	2	3	4	LESS MOTIVATION	0	1	2	3	4
NIGHT SWEATS	0	1	2	3	4	DECREASED MUSCLE STRENGTH	0	1	2	3	4
LOW ENERGY	0	1	2	3	4	BELLY PAIN	0	1	2	3	4
LOW LIBIDO	0	1	2	3	4	FACIAL WRINKLES	0	1	2	3	4
LOW MOOD	0	1	2	3	4	HEADACHES	0	1	2	3	4
VAGINAL DRYNESS	0	1	2	3	4	MORE EMOTIONAL	0	1	2	3	4
SLEEP PROBLEMS	0	1	2	3	4	WEIGHT GAIN	0	1	2	3	4
BRAIN FOG	0	1	2	3	4	COLD HANDS & FEET	0	1	2	3	4
URINE LEAKAGE	0	1	2	3	4	HAIR LOSS	0	1	2	3	4
ACHES & PAINS	0	1	2	3	4	BREAST TENDERNESS	0	1	2	3	4
UTERINE FIBROIDS	0	1	2	3	4	DRY SKIN	0	1	2	3	4
FIBROUS BREASTS	0	1	2	3	4	CONSTIPATION	0	1	2	3	4
MOOD SWINGS	0	1	2	3	4	BRITTLE NAILS	0	1	2	3	4
PMS	0	1	2	3	4	OSTEOPOROSIS	0	1	2	3	4
ASTHMA	0	1	2	3	4	PAINFUL INTERCOURSE	0	1	2	3	4
ALLERGIES	0	1	2	3	4	LOW BODY TEMPERATURE	0	1	2	3	4
IRRITABLE	0	1	2	3	4	LOW BLOOD PRESSURE	0	1	2	3	4
ANXIETY	0	1	2	3	4	LOW PULSE	0	1	2	3	4
DIARRHEA	0	1	2	3	4						

Have you had a hysterectomy? YES or NO

- If NO – when was your last menstrual period? _____

When was your last Mammogram? _____ or Never had a Mammogram

- Have you ever had an abnormal Mammogram? YES or NO

When was your last Pap Smear? _____

- Have you ever had an abnormal Pap Smear? YES or NO