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Patient Name: _____
Patient Phone: _____
Date: _____

Hormone Symptoms Checklist

Please print out this form and bring to *The Medicine Shoppe* for your free initial consultation. With the information you provided on this form, we can determine if a BHRT treatment regimen would be right for you.

Check the following symptoms which are troublesome and persist over time. Two or more symptoms may be an indication of **Estradiol or Progesterone** deficiencies or imbalances.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Apathy | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Decreased Libido |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Foggy Thinking | <input type="checkbox"/> Decreased Urine Flow | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Increased Urinary Urge | <input type="checkbox"/> Headaches | <input type="checkbox"/> Weight Gain-Hips |
| <input type="checkbox"/> Depressed | | | |

Check the following symptoms which are troublesome and persist over time. Two or more symptoms may be an indication of **Testosterone or DHEAS** deficiencies or imbalances.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Decreased Muscle Mass | <input type="checkbox"/> Burned Out Feeling |
| <input type="checkbox"/> Decreased Erections | <input type="checkbox"/> Decreased Mental Sharpness | <input type="checkbox"/> Thinning Skin | <input type="checkbox"/> Oily Skin |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Increased Joint Pain | <input type="checkbox"/> Decreased Stamina | <input type="checkbox"/> Aggression |
| <input type="checkbox"/> Aches and Pains | <input type="checkbox"/> Depression | <input type="checkbox"/> Decrease Urine Flow | <input type="checkbox"/> Irritable |
| <input type="checkbox"/> Foggy Thinking | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Increased Urinary Urge | <input type="checkbox"/> Anxious |
| <input type="checkbox"/> Decreased Flexibility | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Nervous | |

Check the following symptoms which are troublesome and persist over time. Two or more symptoms may be an indication of **Cortisol or adrenal** deficiencies or imbalances.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Anxious | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Chemical Sensitivity |
| <input type="checkbox"/> Weight Gain-Waist | <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Increased Facial Hair | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Decreased Muscle Mass | <input type="checkbox"/> Depressed | <input type="checkbox"/> Increased Body Hair | <input type="checkbox"/> Cold Body Temperature |
| <input type="checkbox"/> Thinning Skin | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Acne | <input type="checkbox"/> Increased Joint Pain |
| <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sugar Cravings | <input type="checkbox"/> Aches/Pains |
| <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Allergies | <input type="checkbox"/> Irritable |

Check the following symptoms which are troublesome and persist over time. Two or more symptoms may be an indication of **thyroid dysfunction**.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Decreased Muscle Mass | <input type="checkbox"/> Bulging Eyes |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Slow Pulse Rate | <input type="checkbox"/> Thinning Skin | <input type="checkbox"/> Erratic Behavior |
| <input type="checkbox"/> Cold Body Temp | <input type="checkbox"/> Decreased Sweating | | <input type="checkbox"/> Anxious |

Thyroid Disfunction Continued

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Infertility Problems | <input type="checkbox"/> Irritable | <input type="checkbox"/> Cold Hands and Feet | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Hair dry/brittle | <input type="checkbox"/> Slowed Reflexes | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Can't Lose Weight | <input type="checkbox"/> Nails Breaking/brittle | <input type="checkbox"/> Constipation | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Memory Lapses | <input type="checkbox"/> Aches/Pains | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Rapid Weight Loss | <input type="checkbox"/> Short Attention |
| <input type="checkbox"/> Decreased Mental | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Rapid Heartbeat | <input type="checkbox"/> Span |
| <input type="checkbox"/> Sharpness | <input type="checkbox"/> Unusual Sweating | <input type="checkbox"/> Goiter | <input type="checkbox"/> Tremors in |
| <input type="checkbox"/> Swelling/Puffy | <input type="checkbox"/> Bone Loss | <input type="checkbox"/> Sleep Disturbances | <input type="checkbox"/> Fingers |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Always feeling lost | <input type="checkbox"/> Mood Changes | |

Check the following symptoms which are troublesome and persist over time. Two or more symptoms may be an indication of **insulin resistance**.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Food/Sugar | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Elevated Triglycerides | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Increased Urinary Urge | <input type="checkbox"/> Low Blood Sugar | <input type="checkbox"/> (hands and feet) |
| <input type="checkbox"/> Weight Gain-Waist | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Difficulty Sleeping | |

Again, please print out this form and bring to *The Medicine Shoppe* for your free initial consultation. With the information you provided on this form, we can determine if a BHRT treatment regimen would be right for you.