

Hormone Symptoms Questionnaire

Name: _____ Date: _____

Do you have any problems with any of the following? Please check all that apply.

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	Yes	No	
Estrogen Def.	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes , Night Sweats or both
	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Loss
	<input type="checkbox"/>	<input type="checkbox"/>	Sad, Blue or Depressed
	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with sleep (falling asleep or staying asleep)
	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory, forgetfulness, diminishing mental skills
	<input type="checkbox"/>	<input type="checkbox"/>	Pain with sex? Dryness, deep penetration, tearing, stretching feeling, other: _____
	<input type="checkbox"/>	<input type="checkbox"/>	Significant vaginal dryness
Prog Def.	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety, Nervous
	<input type="checkbox"/>	<input type="checkbox"/>	Fibroids or Endometriosis
	<input type="checkbox"/>	<input type="checkbox"/>	Break through bleeding or heavier bleeding
	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with sleep (falling asleep or staying asleep)
	<input type="checkbox"/>	<input type="checkbox"/>	More mood swings, or irritability or nervous tension, or anxiety
Testosterone Def.	<input type="checkbox"/>	<input type="checkbox"/>	Lack of motivation, less assertive or loss of that competitive edge
	<input type="checkbox"/>	<input type="checkbox"/>	Lack of sexual desire (libido) less sexual fantasies
	<input type="checkbox"/>	<input type="checkbox"/>	Decreased arousal/less natural lubrication with sex
	<input type="checkbox"/>	<input type="checkbox"/>	Difficult, takes longer, or is not possible to reach orgasm
	<input type="checkbox"/>	<input type="checkbox"/>	Lack of vitality, feel listless, weak or think you are anemic
	<input type="checkbox"/>	<input type="checkbox"/>	Less muscle strength or feeling weaker
	<input type="checkbox"/>	<input type="checkbox"/>	Trouble with problem solving or logic
	<input type="checkbox"/>	<input type="checkbox"/>	Thinning or dry skin
Andro XS	<input type="checkbox"/>	<input type="checkbox"/>	Growth of new or more facial hair, deeper voice, feeling less feminine
	<input type="checkbox"/>	<input type="checkbox"/>	New or increase in acne or oily skin
	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of hostility, anger, agitation or aggressiveness
Thyroid Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue?
	<input type="checkbox"/>	<input type="checkbox"/>	Do you wake up tired?
	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hair? On Head , Body, Loss of pubic hair, eyebrows?
	<input type="checkbox"/>	<input type="checkbox"/>	Cold Hands or Feet
	<input type="checkbox"/>	<input type="checkbox"/>	Brittle hair or brittle nails?
	<input type="checkbox"/>	<input type="checkbox"/>	Exhausted during the day or afternoon, take a nap or wish you could
	<input type="checkbox"/>	<input type="checkbox"/>	Weight gain in the past year: # of pounds _____ in past 5 yrs: # pounds _____
	<input type="checkbox"/>	<input type="checkbox"/>	Trouble losing weight despite regular exercise and dieting
	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any thyroid problems
	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any family members with thyroid problems

Now please circle the 3-4 most concerning symptoms.

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