BHRT Checklist for WOMEN

Patient Name Date

SYMPTOM(S) (please check all that apply)	NEVER	MILD	MODERATE	SEVERE
Depressive mood	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Memory loss	☐	☐	☐	☐
Mental confusion	☐	☐	☐	☐
Decreased sex drive/libido	☐	☐	☐	☐
Sleep problems	☐	☐	☐	☐
Mood changes/irritability	☐	☐	☐	☐
Tension migraine/severe headaches	☐	☐	☐	☐
Difficult to climax sexually	☐	☐	☐	☐
Bloating	☐	☐	☐	☐
Weight gain	☐	☐	☐	☐
Breast tenderness	☐	☐	☐	☐
Vaginal dryness	☐	☐	☐	☐
Hot flashes	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Dry and wrinkled skin	☐	☐	☐	☐
Hair falling out	☐	☐	☐	☐
Cold all the time	☐	☐	☐	☐
Swelling all over the body	☐	☐	☐	☐
Joint pain	☐	☐	☐	☐

FAMILY HISTORY			
Heart disease	☐	Alzheimer’s Disease	☐
Diabetes	☐	Breast Cancer	☐
Osteoporosis	☐		

OVER ➔

Currently pregnant or trying to conceive? ☐ No ☐ Yes

Uterus present? ☐ No ☐ Yes

Still having a menstrual cycle? ☐ No ☐ Yes

Birth control? ☐ No ☐ Yes

Smoker? ☐ No ☐ Yes

Currently on HRT? ☐ No ☐ Yes

Currently on Thyroid medication? ☐ No ☐ Yes

History of breast cancer? ☐ No ☐ Yes

Epilepsy or Seizures? ☐ No ☐ Yes

Fibrocystic breast disease? ☐ No ☐ Yes

PCOS? ☐ No ☐ Yes

History of Leiomyoma or Endometrial Polyps? ☐ No ☐ Yes

Hashimoto's Thyroiditis? ☐ No ☐ Yes

Acne? ☐ No ☐ Yes

Facial hair? ☐ No ☐ Yes

Pre-menstrual migraines? ☐ No ☐ Yes

Breakthrough or postmenopausal bleeding? ☐ No ☐ Yes

Excess libido? ☐ No ☐ Yes