

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

	SCORE:	None 1	Mild 2	Moderate 3	Severe 4	Extremely Severe 5
1. Hot flashes, sweating (episodes of sweating)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Irritability (feeling nervous, inner tension, feeling aggressive)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Anxiety (inner restlessness, feeling panicky)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please share any additional comments about your symptoms you would like to address.

Do you have cold hands and feet? Yes No Do you have daily bowel movements? Yes No

Do you have gas, bloating or abdominal pain after eating? Yes No

Please select your WEEKLY Activity Level based on this criteria → *Physical activity that accelerates heart rate / Breathlessness*

0-1 day per week (Low) 2-3 days per week (Average) More than 3 days per week (High)

Please list any prior hormone therapy?

FOR OFFICE USE ONLY

CHART ID: _____ DOB: _____ APPT DATE: _____