



**McMINN CLINIC**

WORLD CLASS WELLNESS MEDICINE IN BIRMINGHAM

## FEMALE HORMONE SYMPTOM 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	LESS ASSERTIVE	0	1	2	3	4
LOW ENERGY	0	1	2	3	4	DECREASED MUSCLE	0	1	2	3	4
LOW LIBIDO	0	1	2	3	4	STRENGTH	0	1	2	3	4
LOW MOOD	0	1	2	3	4	FACIAL WRINKLES	0	1	2	3	4
VAGINAL DRYNESS	0	1	2	3	4	HEADACHES	0	1	2	3	4
SLEEP PROBLEMS	0	1	2	3	4	MORE EMOTIONAL	0	1	2	3	4
BRAIN FOG	0	1	2	3	4	WEIGHT GAIN	0	1	2	3	4
URINE LEAKAGE	0	1	2	3	4	HANDS AND FEET COLDER	0	1	2	3	4
ACHES AND PAINS	0	1	2	3	4	HAIR LOSS	0	1	2	3	4
UTERINE FIBROIDS	0	1	2	3	4	BREAST TENDERNESS	0	1	2	3	4
FIBROUS BREASTS	0	1	2	3	4	DRY SKIN	0	1	2	3	4
MOOD SWINGS	0	1	2	3	4	CONSTIPATION	0	1	2	3	4
PMS	0	1	2	3	4	BRITTLE NAILS	0	1	2	3	4
ASTHMA	0	1	2	3	4	OSTEOPOROSIS	0	1	2	3	4
ALLERGIES	0	1	2	3	4	PAINFUL INTERCOURSE	0	1	2	3	4
IRRITABLE	0	1	2	3	4	LOW BODY TEMPERATURE	0	1	2	3	4
ANXIETY	0	1	2	3	4	LOW BLOOD PRESSURE	0	1	2	3	4
						LOW PULSE	0	1	2	3	4

HAVE YOU HAD A HYSTERECTOMY? \_\_\_\_\_ No \_\_\_\_\_ Yes

• IF NOT, WHEN WAS YOUR LAST MENSTRUAL PERIOD? \_\_\_\_\_

WHEN WAS YOUR LAST MAMMOGRAM? \_\_\_\_\_

• HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? \_\_\_\_\_ No \_\_\_\_\_ Yes

WHEN WAS YOUR LAST PAP SMEAR? \_\_\_\_\_

• HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? \_\_\_\_\_