Female BHRT Questionnaire

Patient Info

Name_____
Last Middle First

Phone_____ DOB_____

Mild ← → Severe

	(Please Circle)										
Sleep Disruption	NA	1	2	3	4	5	6	7	8	9	10
Irritability	NA	1	2	3	4	5	6	7	8	9	10
Nervousness	NA	1	2	3	4	5	6	7	8	9	10
Mood swings	NA	1	2	3	4	5	6	7	8	9	10
Depression	NA	1	2	3	4	5	6	7	8	9	10
Cramps	NA	1	2	3	4	5	6	7	8	9	10
Breakthrough bleeding	NA	1	2	3	4	5	6	7	8	9	10
Hot flashes	NA	1	2	3	4	5	6	7	8	9	10
Night sweats	NA	1	2	3	4	5	6	7	8	9	10
Vaginal dryness	NA	1	2	3	4	5	6	7	8	9	10
Painful intercourse	NA	1	2	3	4	5	6	7	8	9	10
Breast tenderness	NA	1	2	3	4	5	6	7	8	9	10
Fluid retention	NA	1	2	3	4	5	6	7	8	9	10
Headaches	NA	1	2	3	4	5	6	7	8	9	10
Decreased sex drive	NA	1	2	3	4	5	6	7	8	9	10
Harder to reach climax	NA	1	2	3	4	5	6	7	8	9	10
Decreased motivation	NA	1	2	3	4	5	6	7	8	9	10
Decreased self-confidence	NA	1	2	3	4	5	6	7	8	9	10
Fatigue	NA	1	2	3	4	5	6	7	8	9	10
Loss of recent memory	NA	1	2	3	4	5	6	7	8	9	10
Dry skin	NA	1	2	3	4	5	6	7	8	9	10
Arthritis	NA	1	2	3	4	5	6	7	8	9	10
Hair loss	NA	1	2	3	4	5	6	7	8	9	10
Urinary incontinence	NA	1	2	3	4	5	6	7	8	9	10
Weight gain	NA	1	2	3	4	5	6	7	8	9	10

Patient Signature_____Date_____