Health Assessment for Women

Name: ______________________ Date: ______________

Mail: ______________________

SYMPTOMS (Please Check Box)

	Never	Mild	Moderate	Severe
1) Fatigue	☐	☐	☐	☐
2) Mood Changes: Irritability Anxiety / Nervousness Depression	☐	☐	☐	☐
3) Decreased Mental Ability: Memory Loss Confusion Loss of Focus	☐	☐	☐	☐
4) Hot Flashes / Night Sweats	☐	☐	☐	☐
5) Weight Gain: Bloating Excessive Belly Fat Inability to Lose Weight	☐	☐	☐	☐
6) Decreased Sex Drive: Vaginal Dryness	☐	☐	☐	☐
7) Sleep Problems: Can't Stay Asleep Can't Fall Asleep	☐	☐	☐	☐
8) Cold Hands & Feet / Always Cold	☐	☐	☐	☐
9) Hair loss / Breakage	☐	☐	☐	☐
10) Dry Wrinkled Skin	☐	☐	☐	☐

FAMILY HISTORY (Please Check Box)

	No	Yes
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Breast Cancer	☐	☐