ROCKY MOUNTAIN
HORMONE AND WEIGHT LOSS CLINIC

Symptoms Questionnaire

Patient Name_____ Date of Birth_____

Please circle one of the following categories below to let us know you are feeling at today's appointments

What are your CURRENT Symptoms?

0 means you have no symptoms of this type – 1 means you have very mild symptoms of this type.

5 would be moderate symptoms of this type and 10 means you have severe symptoms of this type.

(P)

Sleep Disturbance	**0 1 2 3 4 5 6 7 8 9 10**	_____
Depression	**0 1 2 3 4 5 6 7 8 9 10**	
Irritability Anxiety	**0 1 2 3 4 5 6 7 8 9 10**	_____
Mood Swings	**0 1 2 3 4 5 6 7 8 9 10**	_____
Migraine Headaches	**0 1 2 3 4 5 6 7 8 9 10**	_____
Palpitations	**0 1 2 3 4 5 6 7 8 9 10**	_____

(E)

Painful Intercourse	**0 1 2 3 4 5 6 7 8 9 10**	_____
Night Sweats	**0 1 2 3 4 5 6 7 8 9 10**	_____
Hot Flashes	**0 1 2 3 4 5 6 7 8 9 10**	_____
Dry Skin	**0 1 2 3 4 5 6 7 8 9 10**	_____
Chronic Fatigue	**0 1 2 3 4 5 6 7 8 9 10**	_____
Restless Leg Syndrome	**0 1 2 3 4 5 6 7 8 9 10**	_____
Hair Loss	**0 1 2 3 4 5 6 7 8 9 10**	_____

(T)

Fatigue	**0 1 2 3 4 5 6 7 8 9 10**	_____
Weight Control	**0 1 2 3 4 5 6 7 8 9 10**	_____
Low Sex Drive	**0 1 2 3 4 5 6 7 8 9 10**	_____
Loss of Muscle Tone	**0 1 2 3 4 5 6 7 8 9 10**	_____
Poor Focus	**0 1 2 3 4 5 6 7 8 9 10**	_____
Body Joint Pain	**0 1 2 3 4 5 6 7 8 9 10**	_____

Memory Lapses	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** _____
Exercise Tolerance	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10** _____