

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"/>				
2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness)		<input type="checkbox"/>				
3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)		<input type="checkbox"/>				
4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings)		<input type="checkbox"/>				
5. Irritability (feeling nervous, inner tension, feeling aggressive)		<input type="checkbox"/>				
6. Anxiety (inner restlessness, feeling panicky)		<input type="checkbox"/>				
7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)		<input type="checkbox"/>				
8. Sexual problems (change in sexual desire, in sexual activity and satisfaction)		<input type="checkbox"/>				
9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence)		<input type="checkbox"/>				
10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)		<input type="checkbox"/>				
11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints)		<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?

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CHART ID: _____ DOB: _____ APPT DATE: _____