______________________________ ______________________________

Date **Name**

____

Phone #

BHRT Assessment

Monthly Self-Evaluation

1. Have you changed dosage or type of *prescription medications*? Yes / No

If yes, describe:____

____

2. How do you take your *BHRT medication*?

____

____

3. What *changes of non-prescriptions* have you made? **i.e. vitamins, minerals, herbs, enzymes, protein supplements, etc.**

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4. After completing Step 5 on the back page, please write questions or other physical complaints.

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5. Please evaluate your symptoms for this month:

	Absent	Mild	Moderate	Severe
Fibrocystic Breast	______	______	______	______
Weight Gain	______	______	______	______
Heavy/Irregular Menses	______	______	______	______
Hot Flashes	______	______	______	______
Dry Skin/Hair	______	______	______	______
Anxiety	______	______	______	______
Depression	______	______	______	______
Night Sweats	______	______	______	______
Vaginal Dryness	______	______	______	______
Headaches	______	______	______	______
Irritability	______	______	______	______
Mood Swings	______	______	______	______
Breast Tenderness	______	______	______	______
Sleeping Disturbances/Insomnia	______	______	______	______
Cramps	______	______	______	______
Fluid Retention	______	______	______	______
Breakthrough Bleeding	______	______	______	______
Fatigue	______	______	______	______
Memory Loss	______	______	______	______
Bladder Symptoms	______	______	______	______
Arthritis	______	______	______	______
Difficulty Reaching Climax	______	______	______	______
Decreased Sex Drive	______	______	______	______
Hair Loss	______	______	______	______