ADVANCED
HORMONE SOLUTIONS

Female Follow-Up Appointment Sheet

Reason for visit:

- ☐ 30 day follow up
- ☐ 4 month followup
- ☐ Post 12 month

Name: ______________________________

Date: ____________________

Please mark whether you have had any of the following symptoms:

	Yes	No
Night Sweats	☐	☐
Hot Flashes: If yes:	☐	☐
1 x per week	☐	
2 x per week	☐	
3 or more	☐	
Pain with Intercourse	☐	☐
Vaginal Dryness	☐	☐
Sleeping Problems	☐	☐
If yes: 1 x per week	☐	
2 x per week	☐	
3 or more	☐	
Urine leaks when cough/sneeze	☐	☐
Improved memory/concentration	☐	☐
Weight Loss	☐	☐
Weight Gain	☐	☐
Hair Loss	☐	☐
Swelling/Water Retention	☐	☐
Depression/Anxiety	☐	☐

	Yes	No
Abnormal vaginal bleeding	☐	☐
Mood swings If yes:	☐	☐
1 x per week	☐	
2 x per week	☐	
3 or more	☐	
Foggy thinking	☐	☐
Migraines	☐	☐
If yes: 1 x per week	☐	
2 or more per week	☐	
Facial breakout	☐	☐
Increase in sexual desire	☐	☐
Increase in energy level	☐	☐
If yes, rate on scale of 1 to 10	☐	
Muscle and/or joint pain	☐	☐
If yes: 1 x per week	☐	
2 x per week	☐	
3 or more	☐	

	Yes	No
Acne	☐	☐
Facial Hair	☐	☐
History of Hair Loss	☐	☐

Please list any questions or concerns you have for the doctor:

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For Office Use Only

<u>Vitals</u>

Weight ____________

Height ____________

BP ____________

Temp ____________