Women’s Hormone Screening Questionnaire

Which symptoms are you currently experiencing?

☐ Hot flashes
☐ Night sweats
☐ Difficulty sleeping
☐ Fatigue or low energy
☐ Mood changes or irritability
☐ Difficulty concentrating or remembering
☐ Irregular menstrual periods
☐ Heavy or painful menstrual periods
☐ Vaginal dryness or discomfort
☐ Reduced sexual desire
☐ Weight or body-composition changes
☐ Hair thinning
☐ Headaches or migraines
☐ Urinary urgency or recurrent urinary symptoms
☐ Other: _____

Where are you in your hormonal transition?

☐ Regular menstrual periods
☐ Irregular menstrual periods
☐ No menstrual period for fewer than 12 months
☐ No menstrual period for 12 months or longer
☐ Menstrual periods stopped following surgery
☐ Unsure

How much are these symptoms affecting your quality of life?

☐ Mildly
☐ Moderately
☐ Significantly

What is your primary hormone-related concern?

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