

SERVY INSTITUTE FOR REPRODUCTIVE ENDOCRINOLOGY

812 CHAFEE AVENUE ~ AUGUSTA, GEORGIA 30904

PHONE 706-724-0228 ~ FAX 706-722-2387

HORMONE EVALUATION QUESTIONNAIRE

Name: _____ Age: _____

Number of Deliveries: _____ Age of youngest child: _____

Date of last menstruation: _____ Are you still cycling? _____

Have you taken any hormone supplement? _____

Describe: _____

Please check any symptom that you have experienced:

Symptoms		Symptoms	
Headaches		Lack of sex drive	
Hot flashes		Vaginal dryness	
Cold sweats		Pelvic discomfort	
Depression		Pelvic pain	
Irritability		Pelvic relaxation	
Anxiety		Heart palpitations	
Lack of energy		Painful joints	
Lack of memory		Breast pain	
Breast secretions		Acne, skin problems	
Painful intercourse		Swelling	
Loss of urine		Frequent urination	
Painful urination		Hair loss	
Excess of hair			

How long have you suffered from these symptoms? _____

Have you had a hysterectomy? _____ Do you have ovaries? _____

When: _____ Why: _____

Comments: _____
