The Center for Women
Obstetrics & Gynecology
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bioTE® CERTIFIED PRACTITIONER

FEMALE POST SYMPTOM ASSESSMENT CHECKLIST

Name: _____ **Date:** _____

Please mark any symptoms:

	Never	Mild	Moderate	Severe
Fatigue	( )	( )	( )	( )
Memory Loss	( )	( )	( )	( )
Mental Confusion	( )	( )	( )	( )
Decreased Sex Drive or Libido	( )	( )	( )	( )
Sleep Problems	( )	( )	( )	( )
Mood Changes or Irritability	( )	( )	( )	( )
Tension	( )	( )	( )	( )
Migraine or Severe Headaches	( )	( )	( )	( )
Difficult to Climax Sexually	( )	( )	( )	( )
Bloating	( )	( )	( )	( )
Weight Gain	( )	( )	( )	( )
Breast Tenderness	( )	( )	( )	( )
Vaginal Dryness	( )	( )	( )	( )
Hot Flashes	( )	( )	( )	( )
Night Sweats	( )	( )	( )	( )
Dry or Wrinkled Skin	( )	( )	( )	( )
Hair Falling Out	( )	( )	( )	( )
Cold All the Time	( )	( )	( )	( )
Swelling All Over the Body	( )	( )	( )	( )
Joint Pain	( )	( )	( )	( )

Are you having any of the following symptoms:

	Yes	No
Acne	( )	( )
Irregular Bleeding	( )	( )
Heavy Bleeding	( )	( )
Facial Hair	( )	( )
Breast Tenderness	( )	( )

How often do you exercise? ( ) 0 Hrs ( ) 1-3 Hrs/Wk ( ) 4-7 Hrs/Wk ( )>8 Hrs/Wk

Do you Smoke? ( ) Yes ( )No

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