



SYMPTOMS CHECKLIST

DATE: ____ / ____ / ____

Lack of Progesterone

- Headache
- Low Libido
- Anxiety
- Swollen Breasts
- Moodiness
- Fuzzy Thinking
- Depression
- Food Cravings
- Irritability
- Insomnia
- Cramps
- Emotional Swings
- Painful Breasts
- Weight Gain
- Bloating
- Inability to Concentrate
- Asthma
- Early Menstruation
- Painful Joints
- Acne

Excess of Progesterone

- Depression
- Somnolence (Sleepiness)

Lack of Testosterone

- Low Libido/Sex Drive
- Low Energy
- Loss of Muscle Tone

Lack of Estrogen

- Hot Flashes
- Shortness of Breath
- Night Sweats
- Sleep Disorders
- Vaginal Dryness
- Dry Skin
- Anxiety
- Mood Swings
- Headache
- Depression
- Memory Loss
- Heart Palpitations
- Yeast Infections
- Vaginal Shrinkage
- Painful Intercourse
- Hair Loss/Dry Hair
- Inability to Reach Orgasm
- Lack of Menstruation

Abundance of Estrogen

- Water Retention
- Fatigue
- Breast Swelling
- Fibrocystic Breasts
- Premenstrual-like Mood
- Loss of Sex Drive
- Heavy/irregular Menses
- Uterine Fibroids
- Craving for Sweets
- Weight Gain



Pertinent History

Date of Birth ____ / ____ / ____

Any drug allergies? If so, list: _____

Are you Lactose intolerant, or have trouble digesting milk, dairy products?

Any family history of:

- Breast cancer
- Cervical/Vaginal cancer
- Other types of cancer _____

Still having periods? _____

Regular/Normal? _____

Irregular/Abnormal? _____

Date of last period: ____ / ____

Are you taking/or have you taken any Prescription or Over-the-Counter hormone replacement meds? _____

If so, list name and strength of Medication: _____

Who is the Doctor you want us to contact for your prescription? _____

Return or Fax:

Pitt Street Pharmacy
111 Pitt Street
Mt. Pleasant, SC sc 29464
(843) 884 4051 phone
(843) 884 9117 fax

Please print:

Name: _____

Address: _____

City: _____

ST/Zip: _____

Day Time Phone: (____) _____

Home Phone: (____) _____

Email: _____