TIER 1
HEALTH AND WELLNESS

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FEMALE
HEALTH & WELLNESS FOLLOW UP VISIT

NAME: _____ DATE: _____

Have your symptoms improved, deteriorated or remained the same since your last visit? (circle one)

If your symptoms have changed since your last visit, please explain: _____

_____

_____

Please check only those symptoms that you are currently experience

Mental fogginess		Increase of breast size	
Forgetfulness		Water Retention	
Depression		Impatient, snappy behavior	
Minor anxiety		Pelvic cramps	
Mood changes		Nausea	
Difficulty falling asleep		Flabbiness and muscular weakness	
Hot flashes		Loss of hair	
Temperature swings		Lack of energy and stamina	
Day long fatigue		Loss of coordination and balance	
Decreased sense of sexuality		Decreased sex drive	
Lessened self-image		Decreased hair (armpit, pubic, body)	
Dry eyes, skin, vagina		Harder to reach climax	
Sagging breasts and loss of fullness		Pain with sexual activity	
Weight gain		Decreased muscle strength	
Joint/body aches and pain		Fibromyalgia	

_____
Please sign your name